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**Australian Institute of
Health and Welfare**

Alcohol and other drug treatment services in Australia 2015–16

DRUG TREATMENT SERIES NO. 29



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Australian Institute of
Health and Welfare

*Authoritative information and statistics
to promote better health and wellbeing*

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Number 29

Alcohol and other drug treatment services in Australia

2015–16

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The Australian Institute of Health and Welfare is a major national agency which provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's purpose is to provide authoritative information and statistics to promote better health and wellbeing among Australians.

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- Health Directorate, Australian Capital Territory
- Department of Health, Northern Territory.

Abbreviations

ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
GHB	gamma hydroxybutyrate
MDMA	3,4-methylenedioxy-N-methylamphetamine (or ecstasy)
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
SLK	statistical linkage key
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Notes

Components of tables may not sum to totals due to rounding.

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia* due to data revisions.

Supplementary tables referred to in this report (tables with the prefix 'S') are available for download from <<http://www.aihw.gov.au/publication-detail/?id=60129559769&tab=3>>.

Summary

Alcohol and other drug (AOD) treatment services across Australia provide a broad range of treatment services and support to people using drugs, and to their families and friends. This report presents information for 2015–16 about publicly funded AOD treatment service agencies, the people they treat, and the treatment provided.

1 in 180 people in Australia received treatment

An estimated 134,000 clients received treatment in 2015–16, an 11% rise since 2013–14 (119,000). This equates to a rate of 650 clients per 100,000 people, or about 1 in 180 people. About two-thirds of clients were male (67%), and half were aged 20–39 (55%). Despite only comprising 2.6% of the population, 1 in 7 (14%) clients were Aboriginal and Torres Strait Islander. This is a rate of 3,400 clients per 100,000 Indigenous Australians, compared with 540 clients per 100,000 non-Indigenous Australians.

Treatment agencies provided about 207,000 treatment episodes in 2015–16—an average of 1.5 episodes per client—and 4 in 5 (79%) episodes ended within 3 months. Of those clients who received treatment in 2015–16, 11% also received treatment in 2013–14 and 2014–15.

Treatment episodes for amphetamines rose by 175% over 5 years

Alcohol, cannabis, amphetamines, and heroin have remained the most common principal drugs of concern for clients since 2006–07. Nationally, alcohol was the most common principal drug of concern in 2015–16, accounting for 32% of episodes.

Between 2011–12 and 2015–16, the number of treatment episodes with amphetamines as the principal drug of concern increased by 175%, and cannabis treatment episodes increased by 40%, while heroin treatment episodes fell by 15%, and alcohol treatment episodes fell by 6%.

For clients aged 30 and over, alcohol was the most common principal drug of concern, while for clients aged 10–29, cannabis was the most common.

In the 5-year period, the proportion of episodes where alcohol was the most common principal drug of concern decreased from 46% to 32%, while the proportion of episodes for amphetamines more than doubled (from 11% to 23%). The number of episodes for clients injecting and smoking or inhaling amphetamines has also increased, with more than 4 times as many clients smoking or inhaling in 2015–16 as in 2011–12.

Almost half of clients received treatment for more than 1 drug

In almost half (45%) of treatment episodes, the client also reported additional drugs of concern. Nicotine and cannabis were the most common additional drugs of concern.

Counselling continues to be the most common type of treatment

Since 2006–07, the proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management, and assessment only being the most common types of treatment. Counselling continues to be the most common main treatment type provided for clients (over one-third of episodes since 2006–07)

1 Introduction

Alcohol and other drug (AOD) treatment services assist people to address their problematic drug use through a range of treatments. Many types of treatment are available in Australia. Most aim to reduce the harm of drug use, while some use a structured drug-free setting with abstinence-oriented interventions to help prevent relapse and develop skills and attitudes that assist clients to make changes leading to drug-free lifestyles (AIHW 2011).

This report presents information for 2015–16 about publicly funded AOD treatment service agencies, the people they treat, and the treatment provided. Between 2013–14 and 2015–16, the estimated number of clients who received treatment increased by 11% (118,760 to 133,895, respectively). Of those clients who received treatment in 2015–16, 11% also received treatment in 2014–15 and 2013–14. This equates to a rate of 560 clients per 100,000 people, or about 1 in 180 people in the general population.

1.1 Drug use in Australia

Drug use can be either licit or illicit (see Glossary). Licit and illicit use of drugs is a significant issue in Australia, and has a substantial societal cost—in 2004–05, it cost an estimated \$56 billion, of which \$8 billion was for illicit drug use (Collins & Lapsley 2008). In 2011, treatment for illicit drug use—including amphetamines, cannabis, cocaine, ecstasy, or opioids—cost an estimated at \$298 million (Smith et al. 2014).

The 2016 National Drug Strategy Household Survey found alcohol and tobacco to be the most common drugs used in Australia, with 77% of Australians aged 14 and over drinking alcohol in the previous 12 months, and 12% smoking tobacco daily (AIHW 2017). Nearly 1 in 5 (17%) people drank at levels that put them at increased risk of harm over their lifetime (more than 2 standard drinks per day on average), while one-quarter (26%) of people drank at least once a month at levels that put them at risk of accident or injury (more than 4 standard drinks in a session).

Although less prevalent than the use of licit drugs, illicit drug use is still relatively common. In 2016, about 2 in 5 people (43%) aged 14 and over reported using illicit drugs in their lifetime, while 1 in 7 (16%) reported using illicit drugs within the previous 12 months (AIHW 2017). Cannabis was the most commonly used illicit drug—more than 1 in 3 (35%) Australians aged 14 and over had used cannabis in their lifetime, while 1 in 10 (10%) had used it in the previous 12 months. Ecstasy and hallucinogens were the second and third most common (11% and 9.4%, respectively) for lifetime use, while pain-killers (analgesics) for non-medical purposes and ecstasy were the second and third most common for recent use (3.6% and 2.2%, respectively).

1.2 National Drug Strategy

Australia has had a coordinated approach to dealing with alcohol and other drugs since 1985. The National Drug Strategy 2010–2015, is the latest cooperative strategy between the Australian Government, state and territory governments and the non-government sector.

It has an overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (MCDS 2011):

- demand reduction to prevent and reduce the use of drugs, support people to recover from dependence and support efforts to promote social inclusion and resilient individuals, families and communities
- supply reduction to reduce the supply of illegal drugs and control and manage the supply of alcohol, tobacco and other legal drugs
- harm reduction to reduce harms to individuals, families and community safety.

Harm reduction actions in the strategy include enhancing treatment 'across settings to provide help at all stages of drug use, particularly for disadvantaged populations', preventing drug overdoses through the use of 'substitution therapies, withdrawal treatment and other pharmacotherapies' and continuing drug diversion programs (MCDS 2011).

1.3 Alcohol and other drug treatment services

AOD treatment services assist people to address their drug use through a range of treatments. Treatment objectives can include reduction or cessation of drug use, as well as improving social and personal functioning. Assistance may also be provided to support the family and friends of people using drugs. Treatment services include detoxification and rehabilitation, counselling, and pharmacotherapy and are delivered in residential and non-residential settings.

In Australia, publicly funded treatment services for AOD use are available in all states and territories. Most of these services are funded by state and territory governments, while some are funded by the Australian Government. Information on publicly funded AOD treatment services in Australia, and the people and drugs treated, are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). The AODTS NMDS is 1 of several NMDSs that collect data under the 2012 National Healthcare Agreement to inform policy and help improve service delivery (COAG 2012).

Other available data sources that support a more complete picture of AOD treatment in Australia include:

- the National Opioid Pharmacotherapy Statistics Annual Data collection
<www.aihw.gov.au/alcohol-and-other-drugs/data-sources/nopsad-2016/>
- the National Hospital Morbidity Database
<www.aihw.gov.au/alcohol-and-other-drugs/aodts/drug-related-hospitalisations>
- the Online Services Report Database <www.aihw.gov.au/alcohol-and-other-drugs/aodts/treatment-by-indigenous-health-organisations>
- the Specialist Homelessness Services collection
<www.aihw.gov.au/alcohol-and-other-drugs/data-sources/aodts-nmds-2014-15/treatment/homelessness-services/>
- the National Prisoner Health Data collection <www.aihw.gov.au/prisoner-health>.

1.4 The AODTS NMDS

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government organisations. Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed (see the Glossary).

This report provides information on the following types of treatment:

- assessment only
- counselling, information and education only
- pharmacotherapy
- rehabilitation
- support and case management only
- withdrawal management (see the Glossary).

The AODTS NMDS collects data about services provided to people who are seeking assistance for their own drug use, and those seeking assistance for someone else's drug use.

The AODTS NMDS does not contain a unique identifier for clients, and information about clients is collected at the episode level. From 2012–13, a statistical linkage key (SLK) was introduced to the collection. Although the SLK is not a unique identifier, it enables the number of clients receiving treatment to be estimated, while continuing to ensure their privacy.

In previous reporting years, SLK data were not available for all clients, so an imputation strategy was developed to estimate the number of clients, and enable reporting at the client level. Imputation was not required for the 2014–15 collection period, due to high rates of valid SLKs. However, due to a lower response rate for New South Wales (91%), imputation was applied to 2015–16 data. Further details on the imputation methodology is in Appendix B.

Data are collected by treatment agencies who forward these data to state and territory government health departments who extract required data according the specifications in the AODTS NMDS. Data are submitted to the AIHW annually for national collation and reporting.

Coverage and data quality

Although, the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government organisations, it is difficult to fully quantify the scope of AOD services in Australia.

People receive treatment for alcohol and other drug-related issues in a variety of settings not in scope for the AODTS NMDS. These include: services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding; hospitals, including admitted patient services, outpatient clinics and emergency departments; prisons, correctional facilities and detention centres; primary health-care services, including general practitioner settings, community-based care, Indigenous-specific primary health-care services, and dedicated substance use services; health promotion services (for example, needle and syringe programs); and accommodation services (for example, halfway houses and sobering-up shelters) (Figure 1.1).

In addition, agencies whose sole function is prescribing or providing dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS, due to the multifaceted nature of service delivery in this sector. These data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection available at <www.aihw.gov.au/alcohol-and-other-drugs/data-sources/nopsad-2016/>.

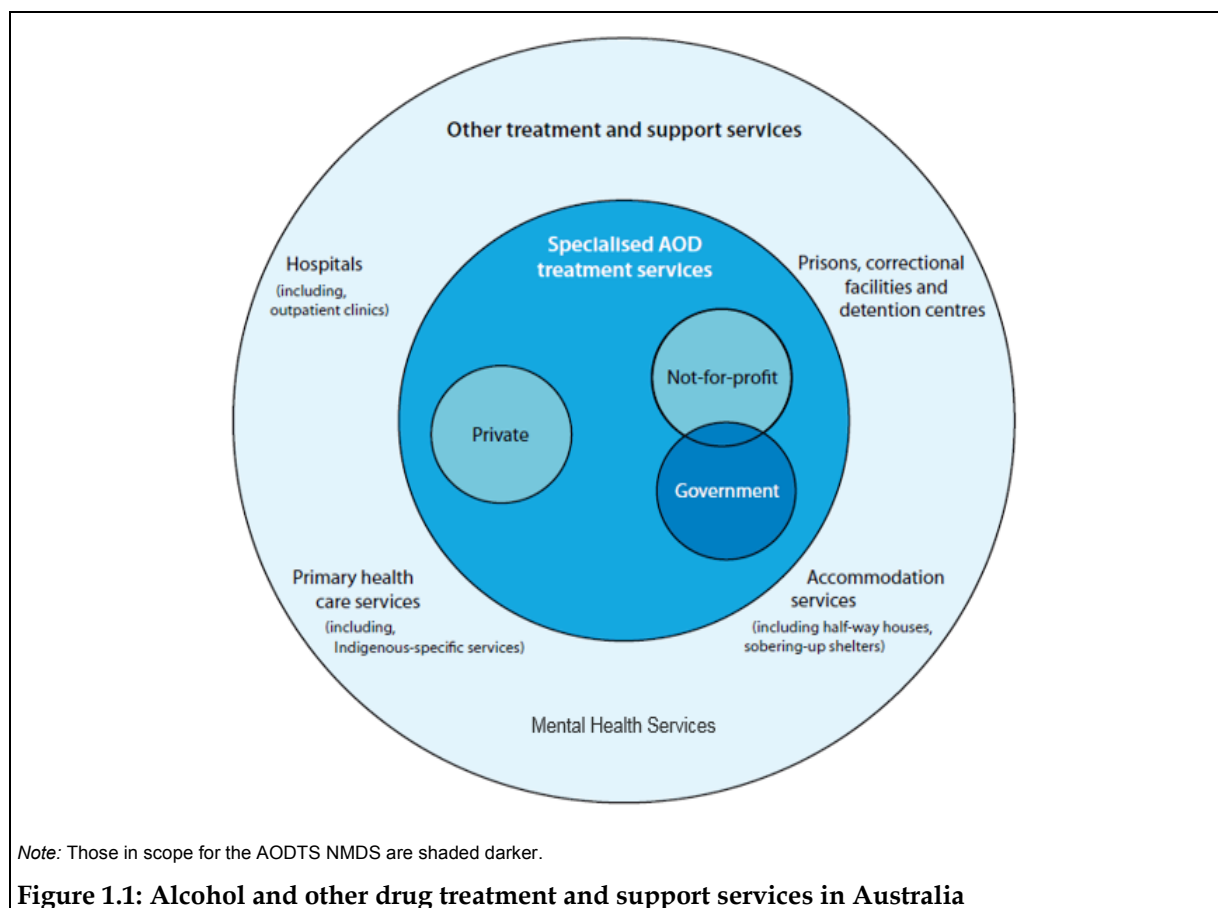


Figure 1.1: Alcohol and other drug treatment and support services in Australia

Australian Government-funded primary health-care services and substance-use services aimed at Indigenous Australians are in scope for the AODTS NMDS. But most of these agencies do not contribute to the collection, because they currently provide data to the Online Services Report collection, for the latest data, see <www.aihw.gov.au/alcohol-and-other-drugs/aodts/treatment-by-indigenous-health-organisations>.

In 2015–16, over 90% (796) of in-scope agencies submitted data to the AODTS NMDS. Overall, there was a decrease of 6 percentage points between 2014–15 and 2015–16, in the proportion of in-scope agencies that reported to the collection. For the 2014–15 reporting period, sector reforms and system issues in some jurisdictions affected the number of in-scope agencies that reported. This led to an under-count of the number of closed treatment episodes reported for that year, so results, especially across reporting years, should be interpreted with caution. Data for 2015–16 has returned to patterns prior to 2014–15.

Further details on scope, coverage, and data quality is available from the AODTS NMDS Data Quality Statement at <<http://meteor.aihw.gov.au/content/index.phtml/itemId/637860>>.

1.5 Report structure

This report provides the following information:

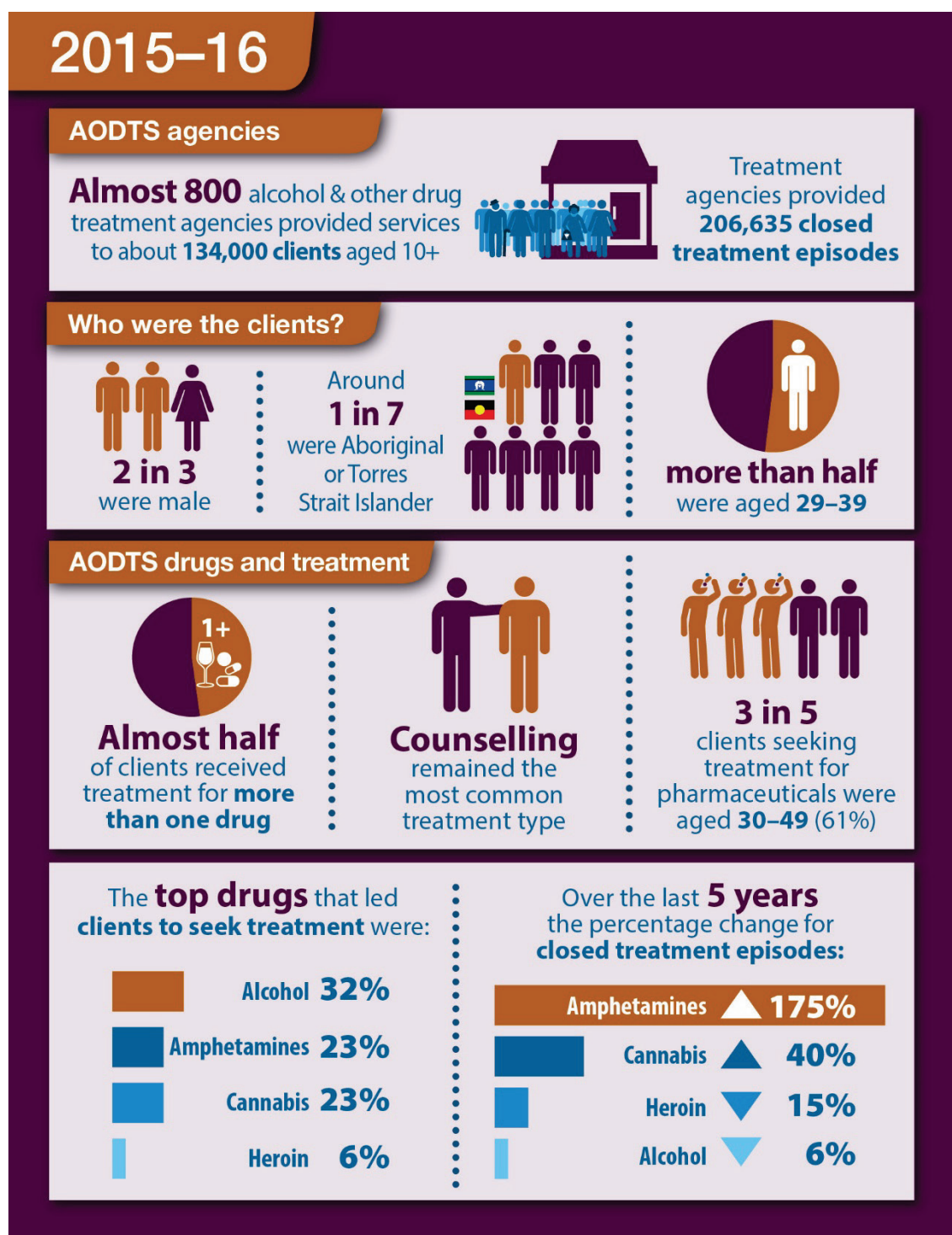
- Chapter 1 'Introduction' (this chapter) provides background information about AOD treatment services in Australia, the AODTS NMDS, and the context in which these data are reported.
- Chapter 2 'At a glance' provides an overview of findings from the 2015–16 AODTS NMDS.
- Chapter 3 'Agencies' presents data on AOD treatment agencies.
- Chapter 4 'Drugs of concern' provides information on the drugs for which people receive treatment.
- Chapter 5 'Treatment provided' looks at the type of treatment provided, including the characteristics of clients and episodes, and the type and outcome of treatment.
- Appendix A 'Data and methods' provides information about the data.
- Appendix B 'Imputation methodology for AODTS clients' provides information about the method used to estimate the number of clients.
- The Glossary provides definitions of terms used in this report.

The following online information accompanies this report:

- Scope, coverage and data quality at
<www.aihw.gov.au/alcohol-and-other-drugs/data-sources/aodts-nmds-2015-16/>
- Data Quality Statement at
<<http://meteor.aihw.gov.au/content/index.phtml/itemId/637860>>
- State and territory summaries at
<<http://www.aihw.gov.au/publication-detail/?id=60129559769>>
- Supplementary data tables (those with a prefix of 'S' referenced throughout the report) at <<http://www.aihw.gov.au/publication-detail/?id=60129559769&tab=3>>.

2 At a glance

This chapter provides an overview of results from the AODTS NMDS for 2015–16.



2.1 Agencies

In 2015–16, a total of 796 publicly funded AOD treatment agencies provided data about services for clients seeking treatment services and support, an increase of 21% over the 5-year period from 2011–12.

Over half (57%) of treatment agencies were non-government, and these agencies provided almost two-thirds (64%) of closed treatment episodes. Nationally, over half (54%) of treatment agencies were located in *Major cities*, and almost one-quarter (24%) were in *Inner regional* areas. Relatively few agencies were located in *Remote* or *Very remote* areas (both 4%) (tables SA.1–SA.3).

2.2 Clients

In 2015–16, an estimated 133,895 clients aged 10 and over received 206,635 closed treatment episodes from publicly funded AOD treatment agencies across Australia (Table 2.1).

This equates to 559 clients per 100,000 people in 2015–16, compared with 510 clients per 100,000 in 2013–14.

Between 2013–14 and 2015–16, the number of estimated clients rose from 118,760 to 133,895, an 11% increase overall (Table 2.1). Despite only comprising 2.6% of the population aged 10 and over, 1 in 7 (14%) clients were Aboriginal or Torres Strait Islander. This is a rate of 3,426 clients per 100,000 Indigenous Australians, compared with 536 clients per 100,000 non-Indigenous Australians (Table SC.26).

Clients' own drug use and someone else's drug use

Clients can receive treatment for their own or someone else's drug use (see Glossary).

In 2015–16, around 198,747 clients received treatment for their own drug use, and around 7,888 received treatment in relation to someone else's drug use (Table 2.1).

A small proportion (less than 1%) of clients received treatment for their own drug use and received support for someone else's drug use in 2015–16.

In 2015–16, clients seeking treatment for their own drug use received an average of 1.5 treatment episodes (Table 2.1), while those receiving treatment for someone else's drug use received an average of 1.2 episodes.

Table 2.1: Clients^(a), treatment episodes, and rates, by client type and state and territory, 2015–16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Own drug use									
Number of episodes	46,301	61,158	43,499	22,554	11,360	3,585	5,774	4,516	198,747
Number of clients	28,995	31,714	35,112	16,361	8,106	2,760	3,459	2,760	128,472
Episodes per client	1.6	1.9	1.2	1.4	1.4	1.3	1.7	1.6	1.5
Rate of episodes ^(b) (per 100,000 population)	534	829	922	986	824	657	1,516	1,926	830
Rate of clients ^(b) (per 100,000 population)	378	529	730	628	476	534	880	378	537
Other's drug use									
Number of episodes	1,070	2,960	1,035	1,652	70	255	140	706	7,888
Number of clients	809	2,387	915	1,590	65	243	132	527	6,674
Episodes per client	1.3	1.2	1.1	1.0	1.1	1.1	1.1	1.3	1.2
Rate of episodes ^(b) (per 100,000 population)	14	49	22	63	4	49	36	289	33
Rate of clients ^(b) (per 100,000 population)	11	40	19	61	4	47	34	216	28
Total									
Number of episodes	47,371	64,118	44,534	24,206	11,430	3,840	5,914	5,222	206,635
Number of clients	29,071	33,312	35,800	17,912	8,109	2,973	3,524	3,209	133,895
Episodes per client	1.6	1.9	1.2	1.4	1.4	1.3	1.7	1.6	1.5
Rate of episodes ^(b) (per 100,000 population)	618	1,069	926	930	671	742	1,505	2,140	863
Rate of clients ^(b) (per 100,000 population)	379	556	744	688	476	575	897	1,315	559

(a) Imputed client numbers based on client records with a valid SLK.

(b) The crude rate is based on the preliminary Australian estimated resident population as at 31 December 2015.

Sources: Tables SC.21 and SC.27.

Client profile

Of all clients receiving treatment, around 2 in 3 (67%) were male, and around 1 in 7 (14%) were Indigenous. These proportions were similar for clients receiving treatment for their own drug use, but clients receiving support for someone else's drug use were more likely to be female (66%), and less likely to be Indigenous (11%) (tables SC.1 and SC.3).

Age

Clients receiving treatment for their own drug use tended to be younger, on average, than those receiving support for someone else's drug use. In 2015–16, clients aged 20–39 represented over half (55%) of clients receiving treatment for their own drug use, but only about one-quarter (25%) of clients receiving support for someone else's drug use. Clients aged 40 and over represented nearly one-third (31%) of clients receiving treatment for their own drug use, compared with over half (57%) of clients receiving support for someone else's drug use (tables SC.2 and SC.3).

Over the 10 years to 2015–16, the proportion of treatment episodes for clients who were aged 20–29 fell from 32% to 28%, while the proportion for those aged 40 and over rose from 27% to 32%, and remained stable for those aged 10–19 and 30–39 (Table SE.5).

Since 2006–07, the median (midpoint) age for all clients rose from 31 to 33. Similarly, for clients seeking treatment for their own use, the median age also ranged from 31 years in 2006–07 to 33 years in 2015–16. For treatment related to another's drug use, clients were generally older, with the median age falling from 43 to 42 over the 10-year period (Table SE.8).

Australia has an ageing population and therefore the absolute numbers of older Australians with AOD issues is expected to increase (Dowling et al. 2008). Further, Gossop (2008) estimates that, internationally, the number of older people needing treatment for AOD issues will double between 2000 and 2020. Although the demographic profile of clients receiving treatment and support from publicly funded AOD services has changed little since 2003–04, in more recent years the age profile of people receiving treatment suggest that there is an ageing cohort of AOD clients.

Indigenous status

Despite only comprising 2.6% of the Australian population, 14% of all clients were Aboriginal or Torres Strait Islander people aged 10 and over in 2015–16 (ABS 2016). This varied by client type – about 1 in 7 (14%) clients receiving treatment for their own drug use, and 11% of clients receiving support for someone else's drug use were Indigenous (Table SC.4).

The main drugs that led clients to seek treatment were alcohol, amphetamines, cannabis, and heroin. This was consistent for both Indigenous and non-Indigenous clients (Table SC.7).

Country of birth and preferred language

The majority of closed treatment episodes were for clients born in Australia, while 72% of the general population was born in Australia (ABS 2017), 87% of treatment episodes were provided to clients who were born in Australia.

Clients receiving treatment that were born in countries other than Australia represented only a small proportion of all clients, with New Zealand and the United Kingdom being the next most common countries of birth (2% and 3%, respectively) (Table SE.9). Comparatively, in 2014–15, 5% of the Australian population were born in the United Kingdom and 2.5% in New Zealand (ABS 2017).

English was the most frequently reported preferred language (93% of treatment episodes) (Table SE.10).

Further information on clients is provided in Chapters 4 and 5.

2.3 Drugs of concern and treatment provided

In 2015–16, AOD treatment services provided a total of 206,635 closed treatment episodes (see Box 4.1), increasing by 21% from 2014–15 (170,367 episodes). This follows a 6% decrease between 2013–14 and 2014–15 due to sector reforms and system changes applied in some jurisdictions that led to changes in reporting for the 2014–15 collection period. However, this increase is a return to the longer-term trend of increasing episodes since 2013–14. The majority (96%) of closed treatment episodes provided in 2015–16 were for clients receiving treatment for their own drug use (Table SE.1).

In 2015–16, the most common principal drugs of concern (the primary drug leading someone to seek treatment, see Box 2.1) were alcohol (32% of episodes), amphetamines (23%), cannabis (23%), and heroin (6%). Since 2011–12, the proportion of episodes where alcohol was the principal drug of concern has decreased from 46% to 32%, while the proportion of episodes for amphetamines increased (from 11% to 23%) (Table SE.11).

In almost half (45%) of closed treatment episodes, the client also reported additional drugs of concern. One-quarter (25%) had 1 additional drug of concern, 12% had 2 drugs, and 1% had 5 drugs. Nicotine (18%) and cannabis (16%) were the most common additional drugs of concern (tables SD.6 and SD.8).

Since 2006–07, the proportion of closed treatment episodes for each main treatment type (see Box 2.1) remained relatively stable. Counselling continues to be the most common main treatment type provided (comprising about 2 in 5 episodes since 2006–07), however, since 2012–13, assessment only has replaced withdrawal management as the next most common (Table ST.2).

In 2015–16, the majority of treatment episodes for clients receiving treatment for their own drug use were provided by non-residential treatment facilities (66%), followed by residential treatment facilities (14%), and outreach settings (12%) (includes any public or private location where services are provided away from the main service location or a mobile service). Episodes provided for the 4 most common principal drugs of concern (alcohol, amphetamines, cannabis, and heroin) were most likely to be provided by non-residential treatment facilities (88% of episodes) (Table SD.12).

In 2015–16, nearly 4 in 5 (79%) closed treatment episodes ended within 3 months. Almost one-third (30%) of closed treatment episodes ended within 1 day, and over one-quarter (26%) ended within 1 month. Only 9% of closed treatment episodes lasted 6 months or longer. Nationally, the median duration of closed treatment episodes in 2015–16 was almost 3 weeks (20 days) (tables SE.21 and SE.22).

3 Agencies

The Australian Government and state and territory governments fund both government and non-government organisations to provide a range of AOD treatment services (see Glossary). Services are delivered in residential and non-residential settings, and include treatment such as detoxification, rehabilitation, counselling, and pharmacotherapy.

The AODTS NMDS contains information on a subset of publicly funded AOD treatment services (see Section 1.4 for details of agencies that are excluded).

Box 3.1: Agencies key facts

In 2015–16:

- a total of 796 publicly funded agencies provided data about services for clients seeking treatment
- nearly 3 in 5 (57%) agencies were non-government
- more than half (54%) of agencies were located in *Major cities*.

Over the 5-year period to 2015–16:

- the number of agencies that are publicly funded providing data about services for clients seeking treatment increased by 17%.

3.1 Number of agencies

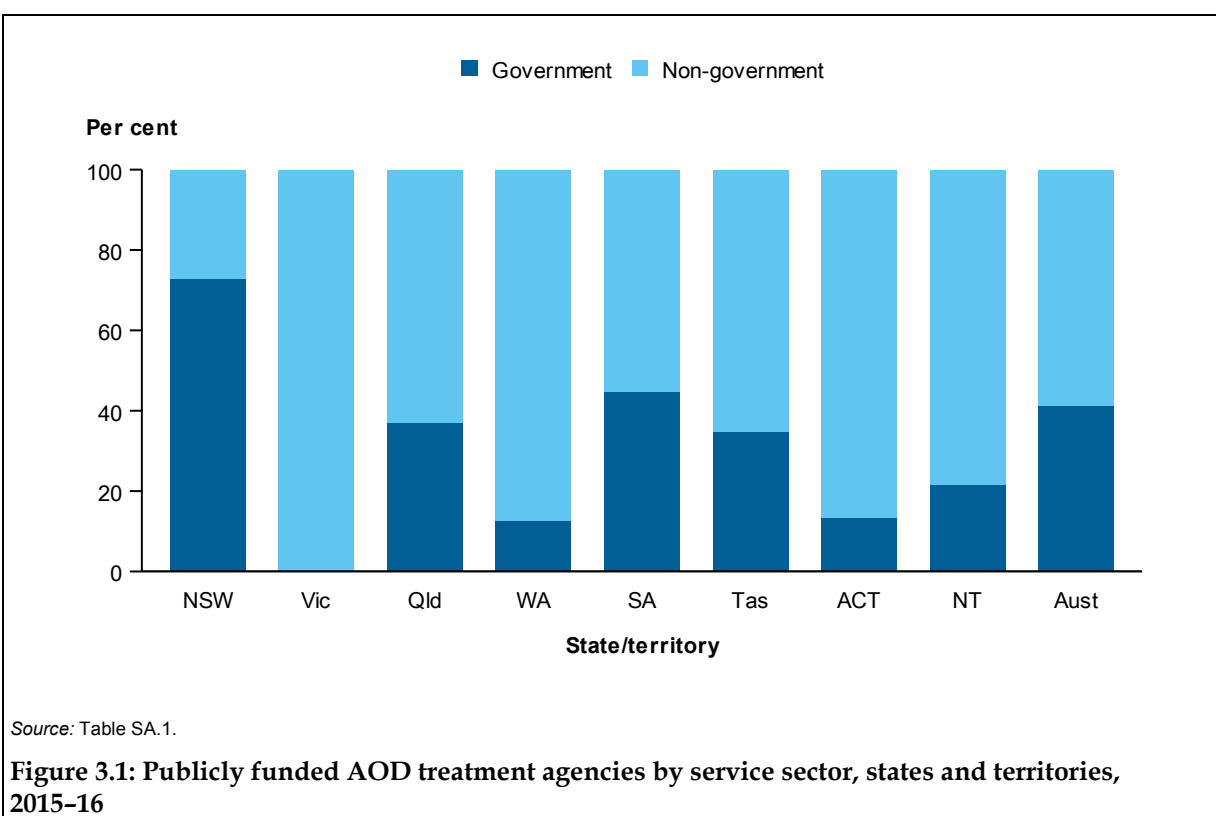
In 2015–16, 796 publicly funded AOD treatment agencies reported to the AODTS NMDS, a decrease of 6% since 2014–15 in the number of agencies nationally. The number of agencies per state and territory ranged from 15 in the Australian Capital Territory to 287 in New South Wales (Table SA.1).

Over the 5-year period to 2015–16, there has been a 17% increase in the number of reporting agencies (from 659 to 796). This rise has largely been driven by increases in reporting agencies in New South Wales (from 263 to 287), Queensland (from 97 to 162), South Australia (from 56 to 78) and Western Australia (from 63 to 79) (Table SA.1).

3.2 Service sector

Nationally, in 2015–16, almost 3 in 5 (57% or 454) AOD treatment agencies were non-government, and these agencies provided almost two-thirds (64% or 132,669) of closed treatment episodes (Figure 3.1). The proportion of non-government agencies has increased since 2006–07 (from 54% to 64%), while the proportion of government agencies has decreased (from 46% to 36%) (Table SA.2).

In New South Wales, the majority of treatment agencies were in the government sector (70%). In the remaining states and territories, most treatment agencies were in the non-government sector, ranging from 63% in South Australia to 100% in Victoria.



3.3 Remoteness area

Nationally, in 2015–16, over half (54% or 432) of the treatment agencies were located in *Major cities* and nearly one-quarter (24%) in *Inner regional* areas. Relatively few agencies were located in *Remote* or *Very remote* areas (both 4%). This pattern was similar across most states and territories, except for Northern Territory where 35% of agencies were located in *Remote* or *Very remote* (22%) areas (Table SA.3).

4 Drugs of concern

People may seek AOD treatment services due to problematic use of 1 or more drugs. For most people, however, there is 1 drug that is of most concern for them, and therefore the focus of the treatment they receive. This is referred to as their principal drug of concern. Clients can also report other drugs of concern (referred to as additional drugs of concern). Information on clients and treatment agencies are included in the AODTS NMDS when a treatment episode provided to a client is closed (Box 4.1).

Box 4.1: Key terminology

Closed treatment episode

A treatment episode is considered closed where any of the following occurs: treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months; or there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they: are not closed in the relevant financial year; are for clients who are receiving pharmacotherapy and not receiving any other form of treatment that falls within the scope of the collection; include only activities relating to needle and syringe exchange; or are for a client aged under 10.

Drugs of concern

Principal drug of concern is the main substance that the client stated led them to seek treatment from the AOD treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses of principal drug of concern. It is assumed that only substance users themselves can accurately report principal drug of concern; therefore these data are not collected from those who seek support for someone else's drug use.

Additional drugs of concern refer to any other drugs the client reports using in addition to the principal drug of concern. Clients can nominate up to 5 additional drugs of concern.

All drugs of concern refer to all drugs reported by clients, including the principal drug of concern and any additional drugs of concern.

Reasons for cessation

The reasons for a client ceasing to receive a treatment episode from an AOD treatment service include:

- *expected cessation*: episodes where the treatment was completed, or where the client ceased to participate at expiration or by mutual agreement
- *unexpected cessation*: episodes where the client ceased to participate against advice, without notice or due to non-compliance
- *administrative cessation*: episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

(continued)

Box 4.1 (continued): Key terminology

Treatment types

Treatment type refers to the type of activity used to treat the client's alcohol or other drug problem. Rehabilitation, withdrawal management (detoxification), and pharmacotherapy are not available for clients seeking support for someone else's drug use.

Main treatment type is the principal activity that is determined at assessment by the treatment provider to be necessary for the completion of the treatment plan for the client's alcohol or other drug problem for their principal drug of concern. One main treatment type is reported for each treatment episode. Assessment only, support and case management only, and information and education only can only be reported as main treatment types.

Other treatment types refer to other treatment types provided to the client, in addition to their main treatment type. Up to 4 additional treatment types can be reported.

Note that Victoria and Western Australia do not supply data on additional treatment types. In these jurisdictions, each type of treatment (main or additional) results in a separate episode.

Box 4.2: Key Facts

In 2015–16:

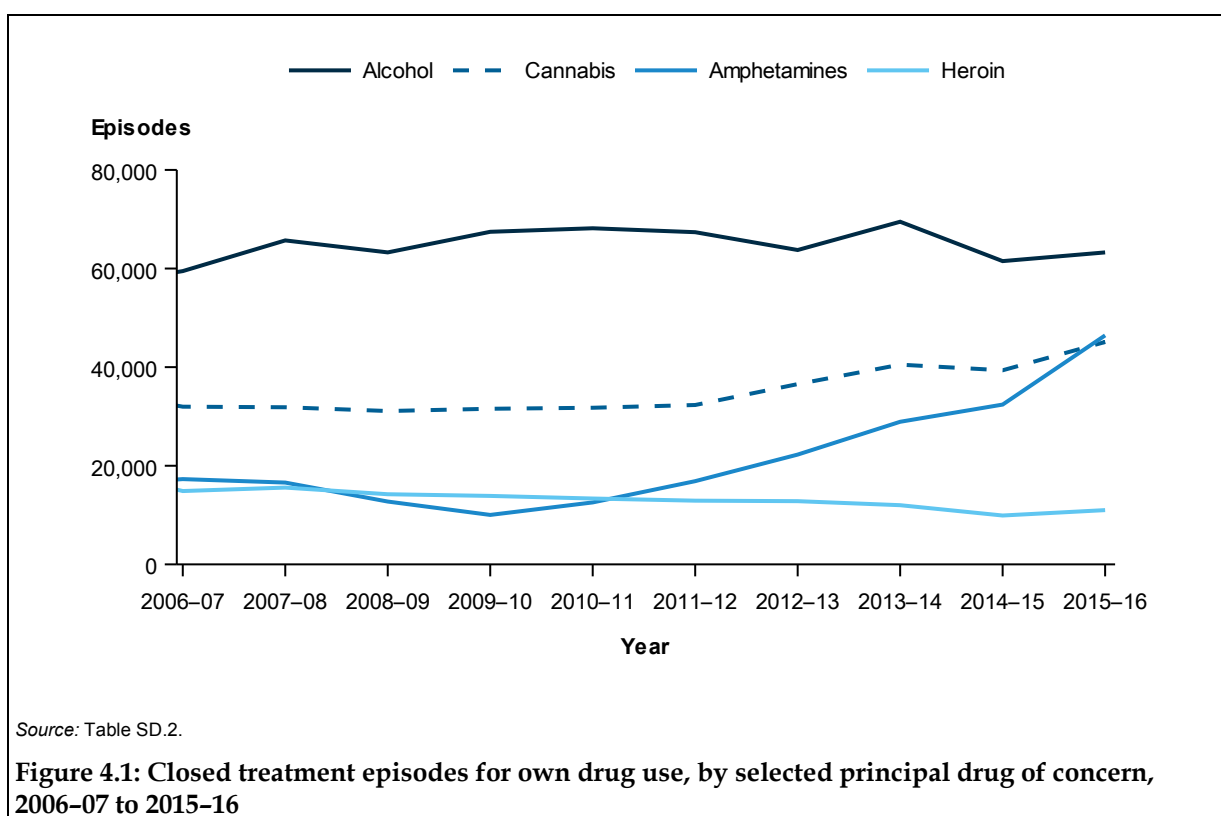
- nationally, alcohol was the most common principal drug of concern, accounting for 32% of episodes (Figure 4.3)
- after alcohol, amphetamines (23%), cannabis (23%), and heroin (6%) were the next most common principal drugs of concern (Figure 4.3) – together, these 4 drugs accounted for 83% of all treatment episodes
- closed treatment episodes for amphetamines rose in all jurisdictions, overtaking alcohol as the top drug of concern in South Australia and Western Australia
- alcohol was the most common principal drug of concern in all remoteness areas, with the highest proportion of treatment episodes located in *Very remote* areas (64%), and the lowest proportion in *Major cities* (30%)
- cannabis was the most common principal drug of concern for clients aged 10–29, while alcohol was the most common for clients aged 30 and over
- for the top 4 principal drugs of concern, most clients received treatment in a non-residential facility – alcohol (68% of episodes for alcohol), cannabis (72%), amphetamines (68%), and heroin (76%)
- clients whose principal drug of concern was heroin generally spent longer in treatment – the median duration of episodes was 39 days compared with 19 days for all treatment episodes.

Over the 5-year period to 2015–16:

- the top 4 principal drugs of concern have remained consistent, though from 2015–16, amphetamines replaced cannabis as the second most common principal drug of concern
- the trend in the top 4 principal drugs of concern has been consistent for both Indigenous and non-Indigenous clients
- the number of closed treatment episodes where amphetamines were the principal drug of concern rose by 175%, while treatment episodes for cannabis rose by 40%
- the number of closed episodes for clients injecting and smoking/inhaling amphetamines rose substantially, with more than 4 times as many clients smoking and inhaling in 2015–16 than in 2011–12.

Although there are many different drugs for which people receive treatment, the most common principal drugs of concern – alcohol, cannabis, heroin, and amphetamines – have accounted for the large majority of services over time (Figure 4.1). Nationally, alcohol has been the most common principal drug of concern since 2006–07, followed by cannabis until 2014–15, when amphetamines became the second most common principal drug of concern. Heroin has maintained its place as the fourth most common principal drug of concern. Due to this consistent trend, the focus of this chapter will be on these drugs.

Where a person receives treatment for someone else’s drug use, the principal drug of concern for that person is not collected. As a result, no information is presented in this chapter on support received by people for someone else’s drug use.

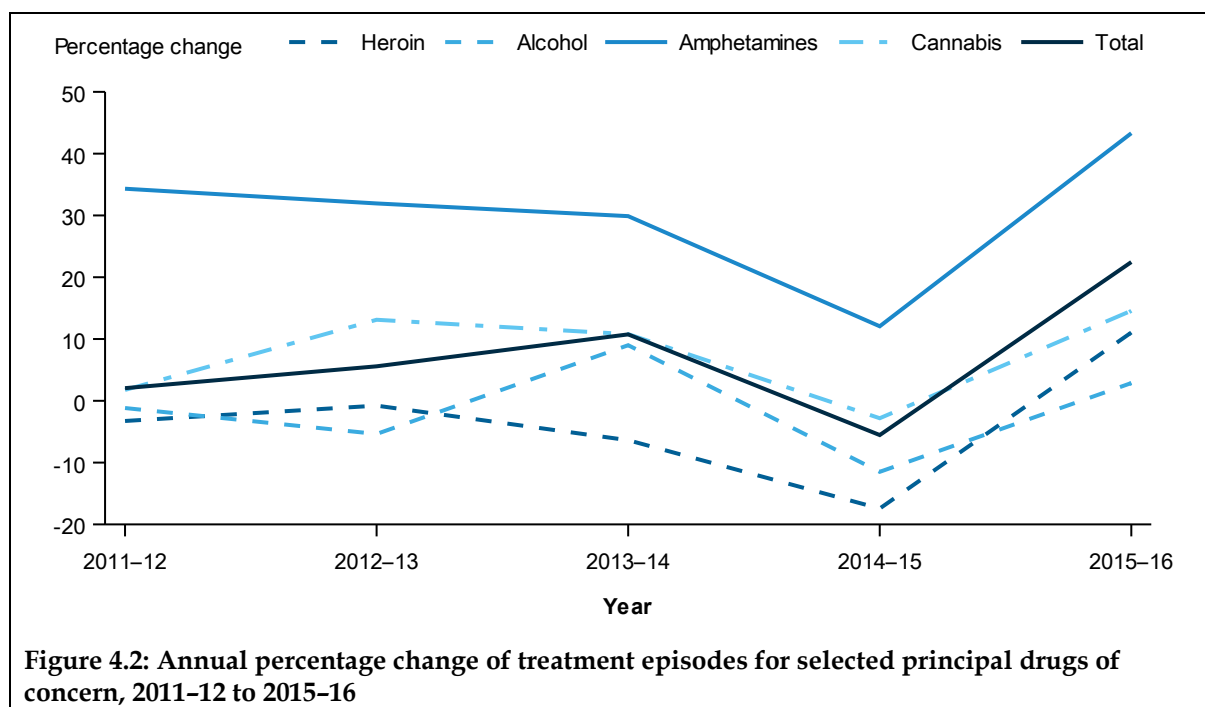


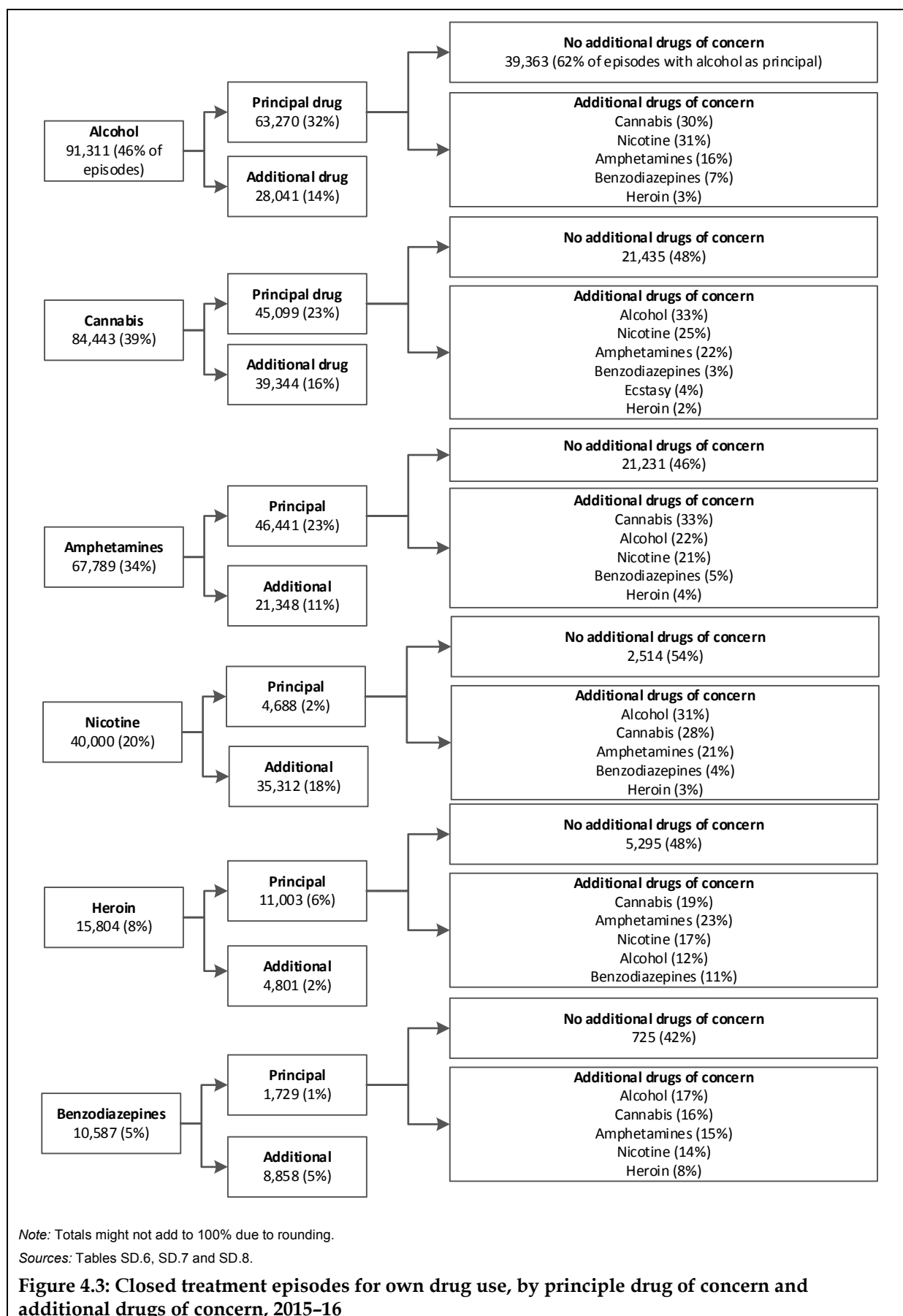
Over the 5-year period from 2011–12 to 2015–16, substantial shifts in treatment activity were reported, with some variance over the years (Figure 4.2).

Overall, the number of closed treatment episodes provided to clients seeking treatment for their own drug use increased by 35% (from 146,948 in 2011–12 to 198,747 in 2015–16). Over the same period, the number of treatment episodes provided for both amphetamines and cannabis also increased substantially – rising by 175% for amphetamines (from 16,875 treatment episodes in 2011–12 to 46,441 in 2015–16), and by 40% for cannabis (from 32,321 to 45,099 episodes). Cannabis showed a proportionally similar rise to that of all episodes of treatment (40% compared with 35%) while the increase for amphetamines was substantially greater (175% compared with 35%). Overall, the number of treatment episodes for heroin fell by 15% over the same period (from 12,918 to 11,003). Alcohol treatment episodes showed a variance in treatment activity during this time but still remains the top drug of concern nationally, even though the actual number of treatment episodes have been gradually declining (Table SD.2).

Declines or increases in certain principal drug episodes in particular years can be subject to administrative anomalies in the data. For example, the drop for all treatment episodes in the 2014–15 collection year might be partly related to sector reforms and system changes leading to temporary changes in reporting for the 2014–15 collection year.

Figure 4.2 shows the percentage change year to year for selected principal drugs of concern in the AODTS NMDS at a national level between 2011–12 and 2015–16.



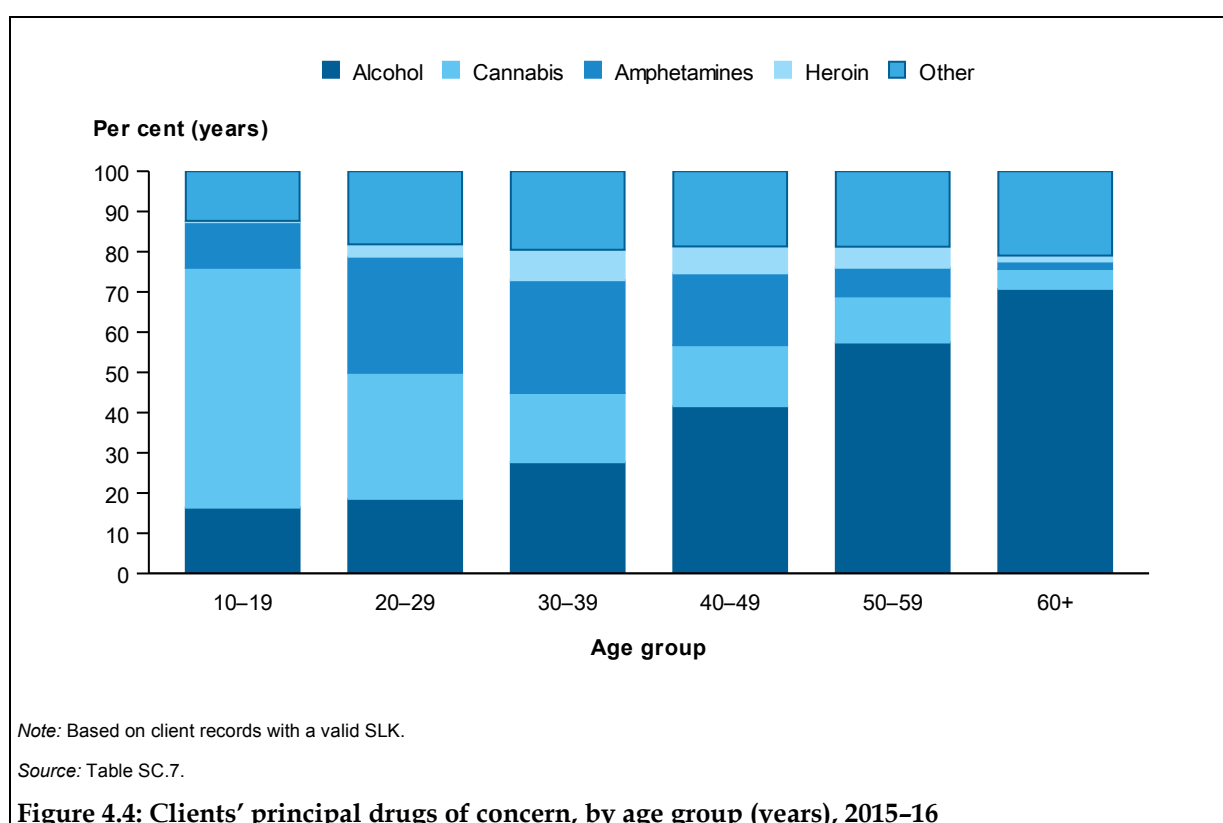


Client demographics

Nationally, at the client level, alcohol was the most common principal drug of concern for 30% of clients, followed by cannabis (26%) and amphetamines (21%) (Table SC.8).

The proportion of clients receiving treatment where alcohol was the principal drug of concern increased substantially with age. Alcohol as a principal drug of concern was more common in the older age groups – 57% of those aged 50–59, and 71% of clients aged 60 and over, whereas it was a principal drug of concern for 1 in 6 (16%) clients aged 10–19 (Figure 4.4).

For clients receiving treatment for cannabis the opposite was true. Those aged 10–29 were most likely to be receiving treatment for cannabis, which was the principal drug of concern for 3 in 5 (60%) clients aged 10–19, compared with 31% of those aged 20–29, 12% of those aged 50–59, and only 5% of clients aged 60 and over.



Clients receiving treatment where amphetamines and heroin were the principal drugs of concern were most likely to be aged 20–49. Amphetamines were most likely to be the principal drug of concern for clients aged 20–39 (39% of those aged 20–29, and 35% of those aged 30–39), whereas only 7% of those aged 10–19, and 3% of clients aged 50+ were receiving treatment for amphetamines. Heroin was most common among clients aged 30–49 (ranging from 43% clients aged 30–39 and to 26% of those aged 40–49), compared with less than 1% of clients aged 10–19, and 11% of clients aged 50+ (Table SC.7).

4.1 Alcohol

Box 4.3: Alcohol

Alcohol is a central nervous system depressant that inhibits brain functions, dampens the motor and sensory centres, and makes judgment, coordination, and balance more difficult (NDARC 2010). According to the 2009 Australian guidelines to reduce health risks from drinking alcohol (NHMRC 2009), people who drink more than 2 standard drinks per day on average have an increased lifetime risk of harm from alcohol-related disease or injury, while those who drink more than 4 standard drinks on a single occasion are at risk of harm on that occasion.

Results from the 2016 National Drug Strategy Household Survey (AIHW 2017) showed that:

- about 77% of Australians aged 14 and over drank alcohol in the previous 12 months
- a significant proportion of the Australian population drank at risky levels – 1 in 5 (17%) aged 14 and over drank at a level that put them at risk of alcohol-related harm over their lifetime, while 1 in 4 (26%) drank at levels that put them at risk of harm from a single drinking occasion at least once in the previous 12 months
- males were more likely than females to drink at levels that placed them at risk of harm over their lifetime as well as on a single occasion.

In 2015–16, alcohol was a drug of concern (principal or additional) in 46% of closed episodes, and the most common principal drug of concern (32% or 63,270 of all closed treatment episodes, and for 30% of clients) (Figure 4.3; tables SD.8 and SC.4). This was consistent for both Indigenous and non-Indigenous clients, but the proportion of closed episodes where alcohol was the most common principal drug of concern was higher for Indigenous clients – 34% compared with 30% for non-Indigenous clients (Table SC.7). In 38% of episodes where alcohol was the principal drug of concern, the client reported additional drugs of concern, most commonly cannabis (30%) or nicotine (31%) (Figure 4.3).

For around one-third (33%) of clients who received treatment during both 2014–15 and 2015–16, alcohol was the main drug that led them to seek treatment (Table SC.36).

Of the clients receiving treatment across all 3 collection years from 2013–14 to 2015–16, a similar proportion of clients (36%) sought treatment for alcohol as a main drug of concern (Table SC.31).

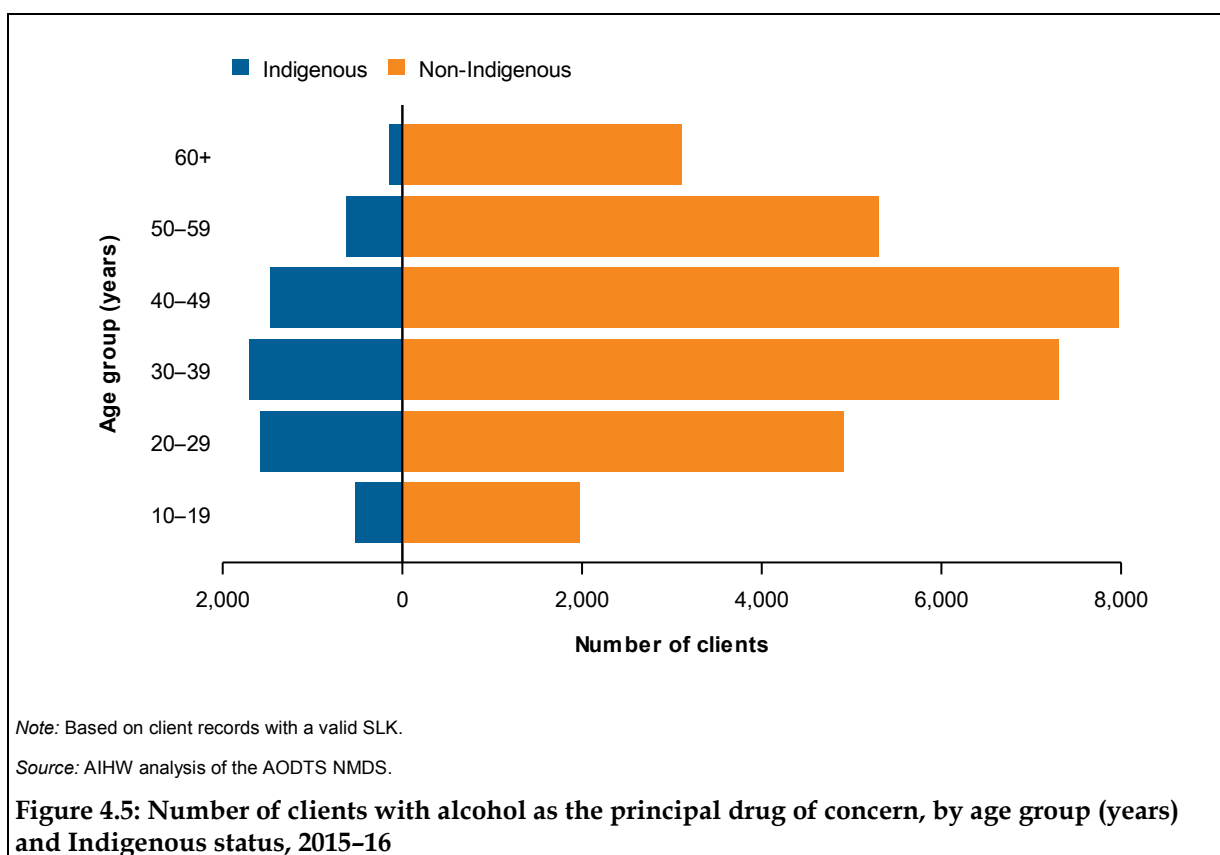
Over the 5 years to 2015–16, the proportion of closed treatment episodes where alcohol was the principal drug of concern fell from 46% to 32% (Table SD.2).

Client demographics

In 2015–16, more than two-thirds of clients whose principal drug of concern was alcohol were male (65%), and 1 in 7 were Indigenous (14%) (Tables SC.4–6). Indigenous Australians (1,140 per 100,000 population) were more likely to have received treatment for alcohol as a principal drug of concern than non-Indigenous Australians (160 per 100,000 population) (Table SC.26).

Clients with alcohol as their principal drug of concern were most likely to be aged 40–49 (26% of clients), followed by 50+ (25%) and 30–39 (24%) (Table SC.6).

Indigenous clients whose principal drug of concern was alcohol tended to be younger, with over half (54%) aged 20–39, compared with 40% of non-Indigenous clients in this age group (Figure 4.5).



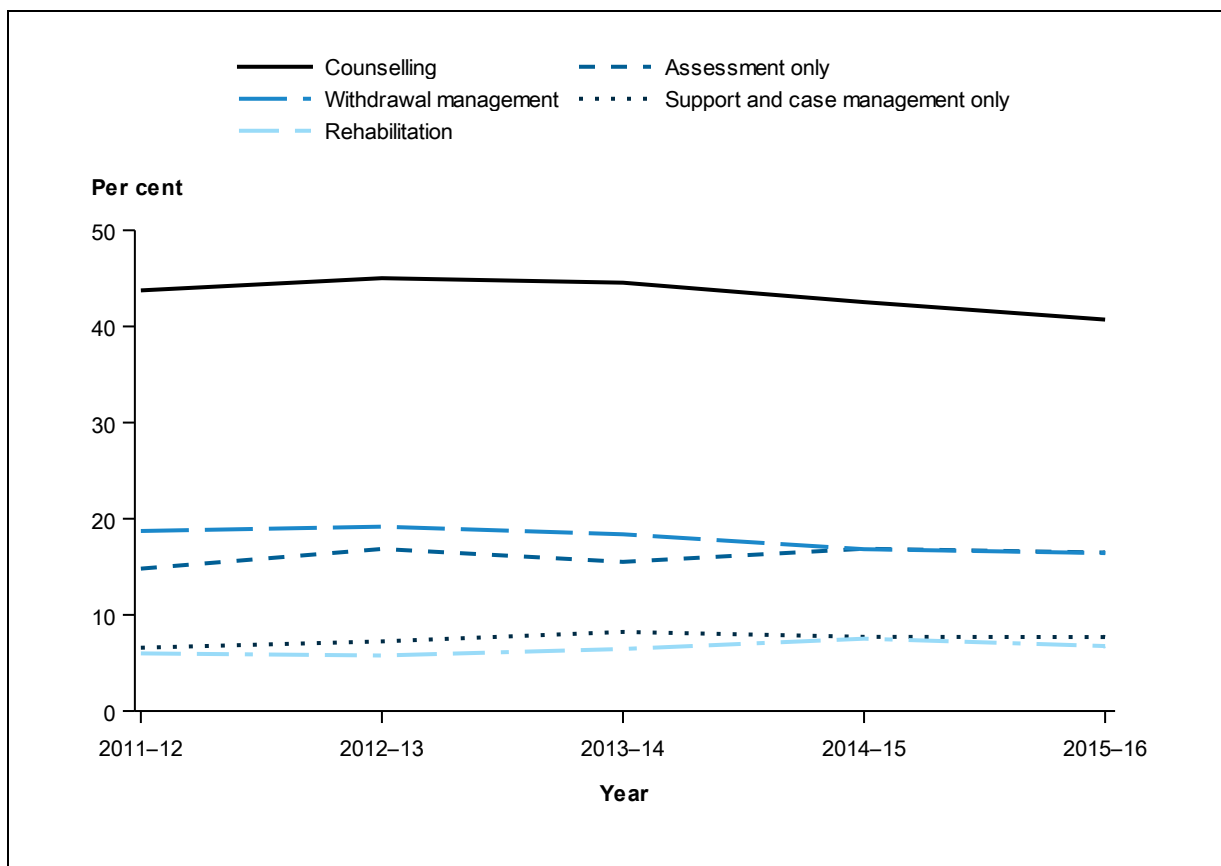
Treatment

In 2015–16, where alcohol was the principal drug of concern, the most common source of referral for closed treatment episodes was self/family (41%), followed by a health service (36%) (Table SD.21).

The most common main treatment type was counselling (41% of closed treatment episodes), followed by withdrawal management and assessment only (both 16%) – this was consistent across all age groups (Table SD.25).

Over the 5 years to 2015–16, counselling, withdrawal management, and assessment only have remained the most common main treatment types for closed treatment episodes where alcohol was the principal drug of concern (Figure 4.6).

More than half (52%) of closed treatment episodes with alcohol as the principal drug lasted less than 1 month (21% ended within 1 day) (Table SE.25). The median duration of episodes with alcohol as the principal drug of concern was 4 weeks (27 days) (Table SD.33).



Source: Table SD.26.

Figure 4.6: Closed treatment episodes with alcohol as the principal drug of concern, by the top 5 treatment types received, 2011-12 to 2015-16

Alcohol-related treatment episodes were most likely to take place in a non-residential treatment facility (68%), with almost one-fifth (17%) occurring in a residential treatment facility.

Where counselling was the main treatment type most episodes (90%) took place in a non-residential treatment facility, while episodes with a main treatment type of withdrawal management were most likely to take place in a residential treatment facility (51%) (Table SD.28).

Almost two-thirds (65%) of closed episodes where alcohol was the principal drug of concern ended with an expected cessation, while 19% ended unexpectedly (that is, the client ceased to participate against advice, without notice or due to non-compliance). Expected cessations were most common where the referral source was self/family (40%) (Table SD.29).

For more information on the groupings for reasons for cessation of treatment, see Appendix A (Table A3).

4.2 Cannabis

Box 4.4: Cannabis

Cannabis (also called marijuana or gunja) is derived from the cannabis plant (usually *Cannabis sativa*), and is used in whole plant (typically the flowering heads), resin, or oil forms. Cannabis has a range of stimulant, depressant, and hallucinogenic effects. The risks associated with long-term or regular use of cannabis include addiction, damage to lungs and lung functioning, effects on memory and learning, and psychosis and other mental health conditions. Cannabis withdrawal is now listed as a discrete syndrome in the Diagnostic and Statistical Manual of Mental Disorders (NCPIC 2011). According to the 2016 National Drug Strategy Household Survey (AIHW 2017), 1 in 3 Australians aged 14 and over have used cannabis at some point in their lifetime, while 1 in 10 have used it in the previous 12 months.

In 2015–16, cannabis was a drug of concern (principal or additional) in 39% of episodes, and was the third most common principal drug of concern (23% or 45,099 of closed treatment episodes) (Figure 4.3; Table SD.8). In more than half (53%) of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern. This was most commonly alcohol (33%), nicotine (25%), or amphetamines (22%) (Figure 4.3; Table SD.7).

Around 1 in 5 clients (19%) who received treatment in both 2014–15 and 2015–16, cannabis was the main drug that led them to seek treatment (Table SC.36).

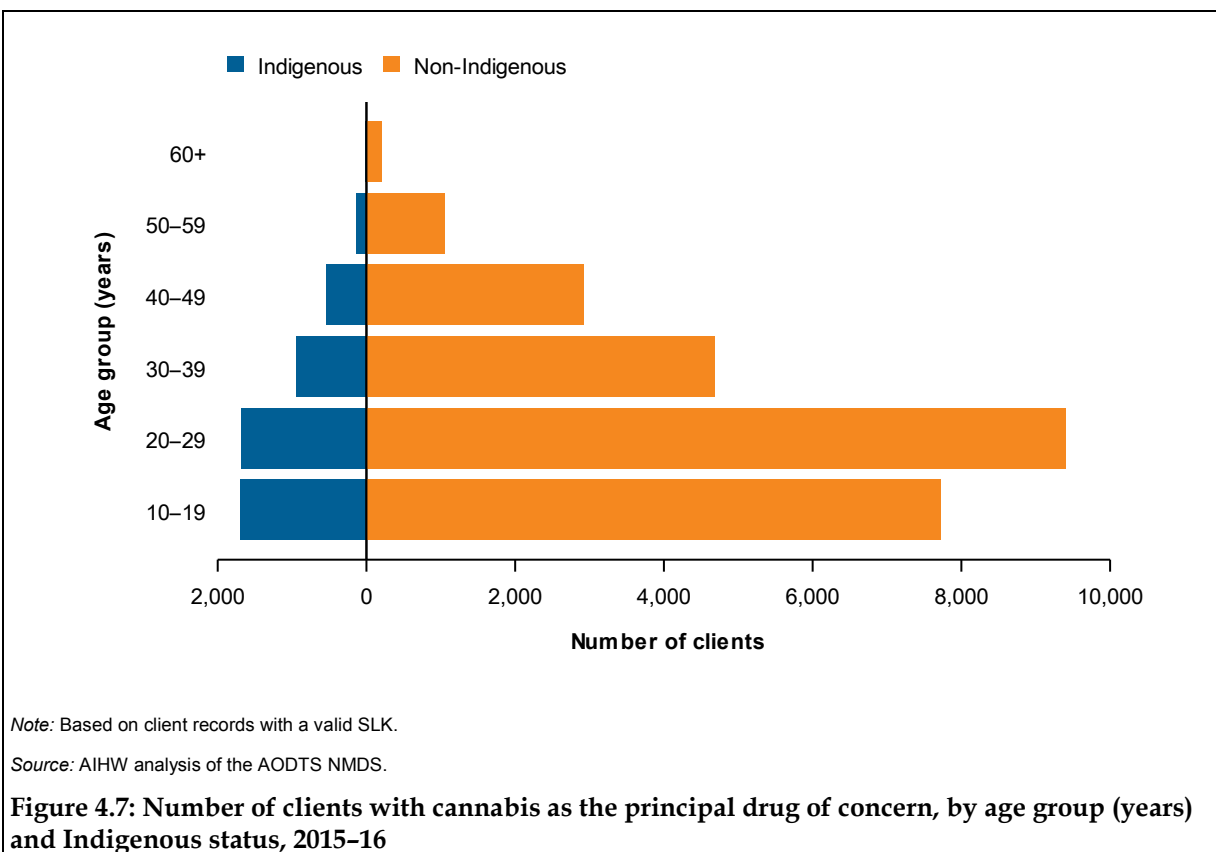
Of the clients receiving treatment across all 3 collection years from 2013–14 to 2015–16, around 1 in 7 clients (15%) sought treatment for cannabis as a main drug concern (Table SC.31).

The proportion of episodes where cannabis was the principal drug of concern have steadily increased over the 5 years to 2015–16. But for the first time since the collection began, amphetamines overtook cannabis as the second most common principal drug of concern in most states and territories in 2015–16. In Queensland, cannabis was the top principal drug of concern in 2014–15 and 2015–16 (Table SD.2).

Client demographics

In 2015–16, where cannabis was the principal drug of concern, nearly three-quarters of clients were males (71%), and around 1 in 6 were Indigenous (16%) (tables SC.5 and SC.7). Where cannabis was the principal drug of concern, Indigenous Australians (970 per 100,000 population) were more likely to have received treatment than non-Indigenous Australians (135 per 100,000 population) (Table SC.26).

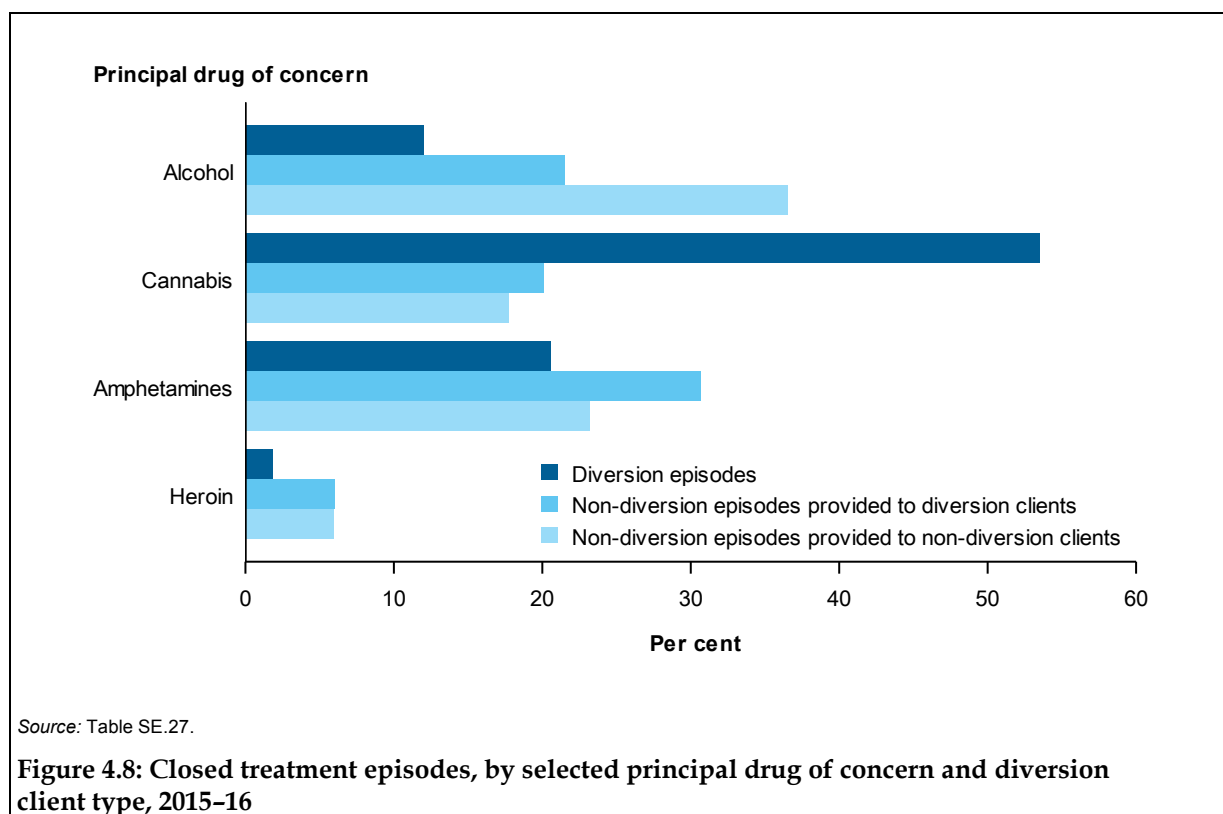
For two-thirds (66%) of clients aged 10–29, cannabis was most likely to be the principal drug of concern (Tables SC.5–7). This pattern was similar for both Indigenous and non-Indigenous clients (Figure 4.7).



Treatment

The most common source of referral for treatment episodes where cannabis was the principal drug of concern was diversion (that is, referred from the criminal justice system into AOD treatment for drug or drug-related offences) (36%), followed by self/family (28%) (Table SD.37).

Of the top 4 principal drugs of concern, cannabis (54%) was the only drug where diversion was the most common source of referral (Figure 4.8). Some diversion clients also received treatment where the source of referral was not related to diversion within the same year, such as amphetamines (21% of closed episodes for diversion only and 31% receiving diversion and non-diversion treatment episodes) (see Glossary) (Figure 4.8).



Where cannabis was the principal drug of concern, counselling was the most common main treatment type (38%), followed by information and education only (23%) (Table SD.42).

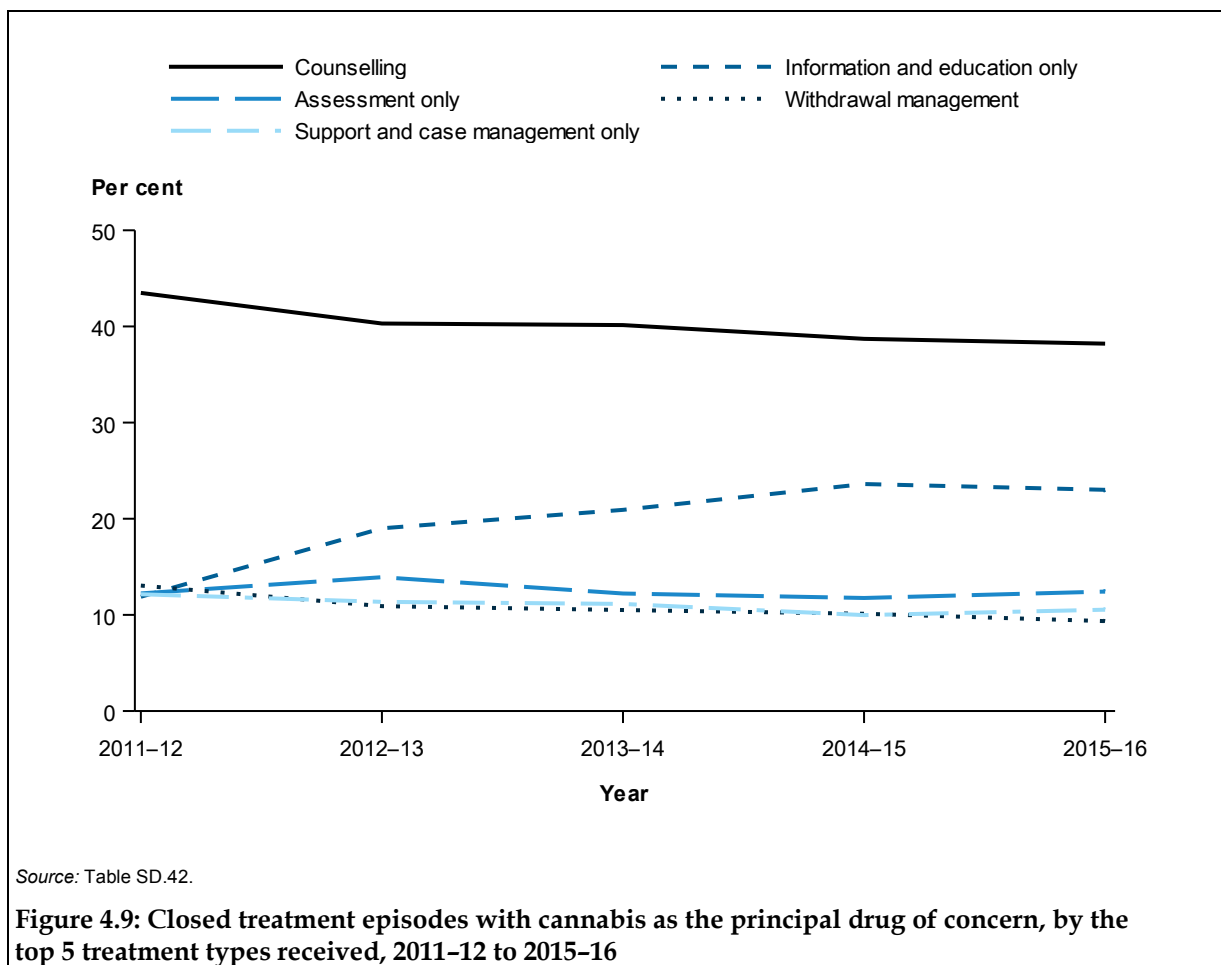
Treatment episodes where cannabis was the principal drug of concern were most likely to take place in a non-residential treatment facility (72%). Most (85%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table SD.44).

Since 2011–12, the proportion of cannabis episodes with a main treatment type of counselling remained the most common form of treatment, followed by information and education only increasing from 12% to 23% as a result of diversion programs (Figure 4.9; Table SD.42).

Where cannabis was the principal drug of concern, 3 in 5 (60%) episodes lasted less than 1 month (38% ended within 1 day) (Table SE.25). The median duration of episodes with cannabis as the principal drug of concern was just under a fortnight (13 days) (Table SD.47).

Episodes with support and case management only as the main treatment type had a median duration of about 8 weeks (56 days), followed by counselling (47 days), and pharmacotherapy (45 days). Withdrawal management treatment episodes had the shortest duration, at just over 1 week (8 days) (Table SD.47).

Almost three-quarters (71%) closed episodes where cannabis was the principal drug of concern ended with an expected cessation, and expected cessations were most common for episodes where the client was diverted from the criminal justice system (52%). Around 1 in 5 (17%) episodes ended unexpectedly (Table SD.45).



4.3 Amphetamines

Box 4.5: Amphetamines

Amphetamines stimulate the central nervous system, and can result in euphoria, increased energy, decreased appetite, paranoia, and increased blood pressure (ADCA 2013). Long-term effects include: high blood pressure, extreme mood swings, depression, anxiety, psychosis, and seizures. There is no approved pharmacotherapy for the management of amphetamine withdrawal or replacement therapy (Lee et al. 2007). According to the 2016 National Drug Strategy Household Survey (AIHW 2017), 1 in 16 (6.3%) Australians aged 14 and over have used meth/amphetamines for non-medical purposes at some point in their lifetime, while 1 in 70 (1.4%) have used them in the previous 12 months.

The AODTS NMDS data available for amphetamines correspond to the ASCDC for the general 'amphetamines' classification, in which methylamphetamine is a sub-classification. Data on different forms of amphetamines, methylamphetamine specifically, are not separately reported due to the nature of the classification structure used in this collection.

A client's usual method of administering their principal drug of concern can provide an indication of the form a client used, particularly for amphetamines. For example, those smoking (clients who report either smoking or inhaling amphetamines) will be using the crystal form, and those ingesting or snorting are most likely to be using the powder form.

In 2015–16, amphetamines were a drug of concern (principal or additional) in 34% of closed treatment episodes, overtaking cannabis nationally as the second most common principal drug of concern (23% or 46,441 of all episodes nationally, and 21% of clients) (Figure 4.3; tables SD.8 and SC.8). This was consistent for both Indigenous and non-Indigenous clients, with amphetamines being the most common principal drug of concern for 22% of Indigenous clients and 21% of non-Indigenous clients (Table SC.7).

Where amphetamines were the principal drug of concern, Indigenous Australians (782 per 100,000 population) were more likely to have received treatment than non-Indigenous Australians (115 per 100,000 population) (Table SC.26). Although a small number of episodes were reported nationally for Indigenous clients for whom amphetamines were a principal drug of concern (almost 7,000), this represents a larger proportion of the Indigenous population across Australia compared with the non-Indigenous population.

In more than half (54%) of episodes with a principal drug of concern of amphetamines, the client reported additional drugs of concern. These were most commonly cannabis (33%), alcohol (22%) and nicotine (21%) (Figure 4.3) (tables SD.6 and SD.7).

One-quarter of clients (25%) who received treatment during both 2014–15 and 2015–16, amphetamines were the main drug that led them to seek treatment (Table SC.34).

Of the clients receiving treatment across all 3 collection years from 2013–14 to 2015–16, almost one-quarter of clients (23%) sought treatment for amphetamines as a main drug of concern (Table SC.31).

In 2015–16, smoking/inhaling was the most common usual method of use (50% of episodes), followed by injecting (38%) (Table SD.55).

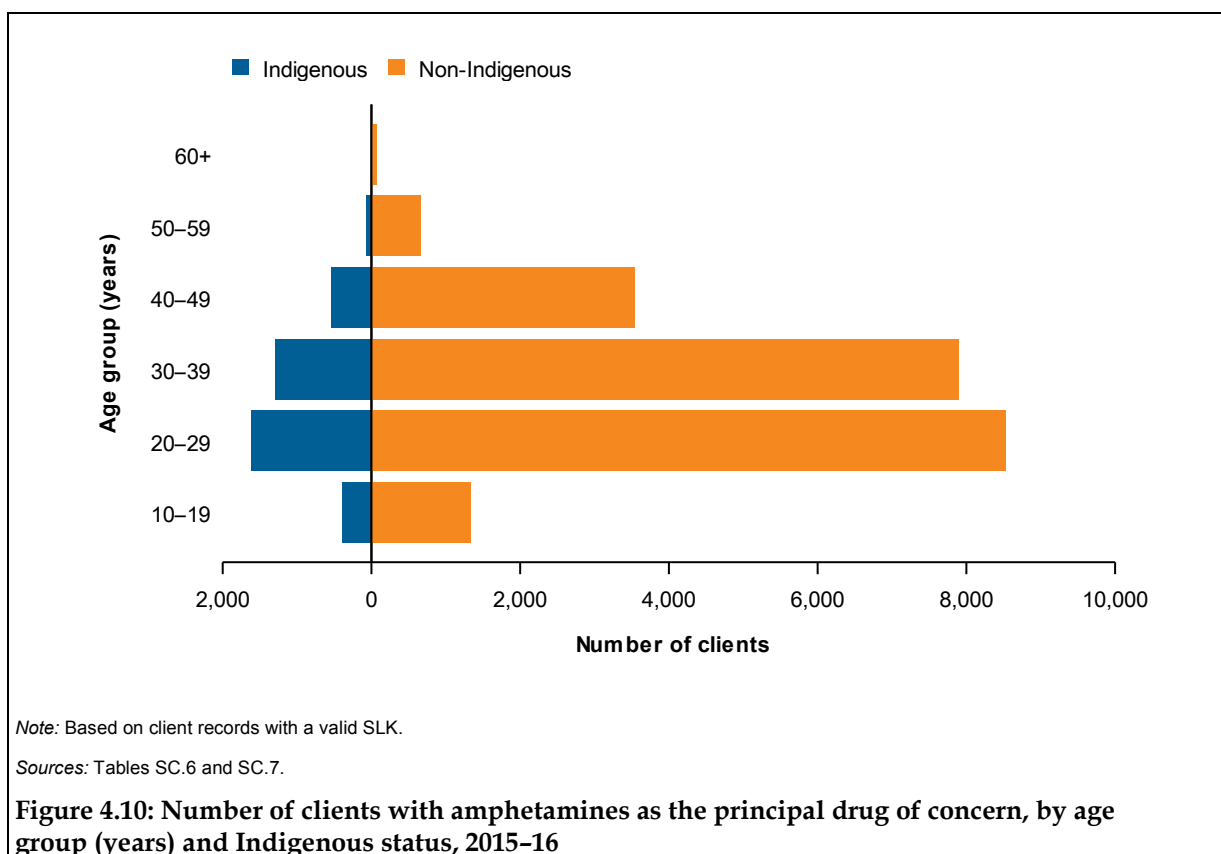
Over the 5 years to 2015–16, the proportion of episodes with amphetamines as the principal drug of concern rose from 12% to 23%. In 2015–16 AOD treatment services provided a total of 46,441 closed treatment episodes where amphetamines were the principal drug of concern. Since 2006–07, the number of amphetamine treatment episodes has risen by 63% (17,292 closed episodes), despite falling to a low of 7% in 2009–10 (Table SD.2).

According to the 2016 National Drug Strategy Household Survey (AIHW 2017), the proportion of the adult population using methamphetamine fell between 2010 and 2016, from 2.1% to 1.4%). However, among recent methamphetamine users, there was a change in the main form used, with a significant increase in the use of crystal methamphetamine or ‘ice’ (from 22% to 57% over the same time period).

Client demographics

In 2015–16, more than two-thirds of clients receiving treatment for amphetamines as a principal drug of concern were male (69%), and about 1 in 7 clients were Indigenous (14%).

Clients with a principal drug of concern of amphetamines were most likely to be aged 20–39 (74%), followed by those aged 40–49 (16%) (Tables SC.5–7). The age profile was similar for Indigenous clients; however, the proportion of clients aged 10–19 was higher for Indigenous clients (10%) compared with 6% for non-Indigenous clients of the same age (Figure 4.10).

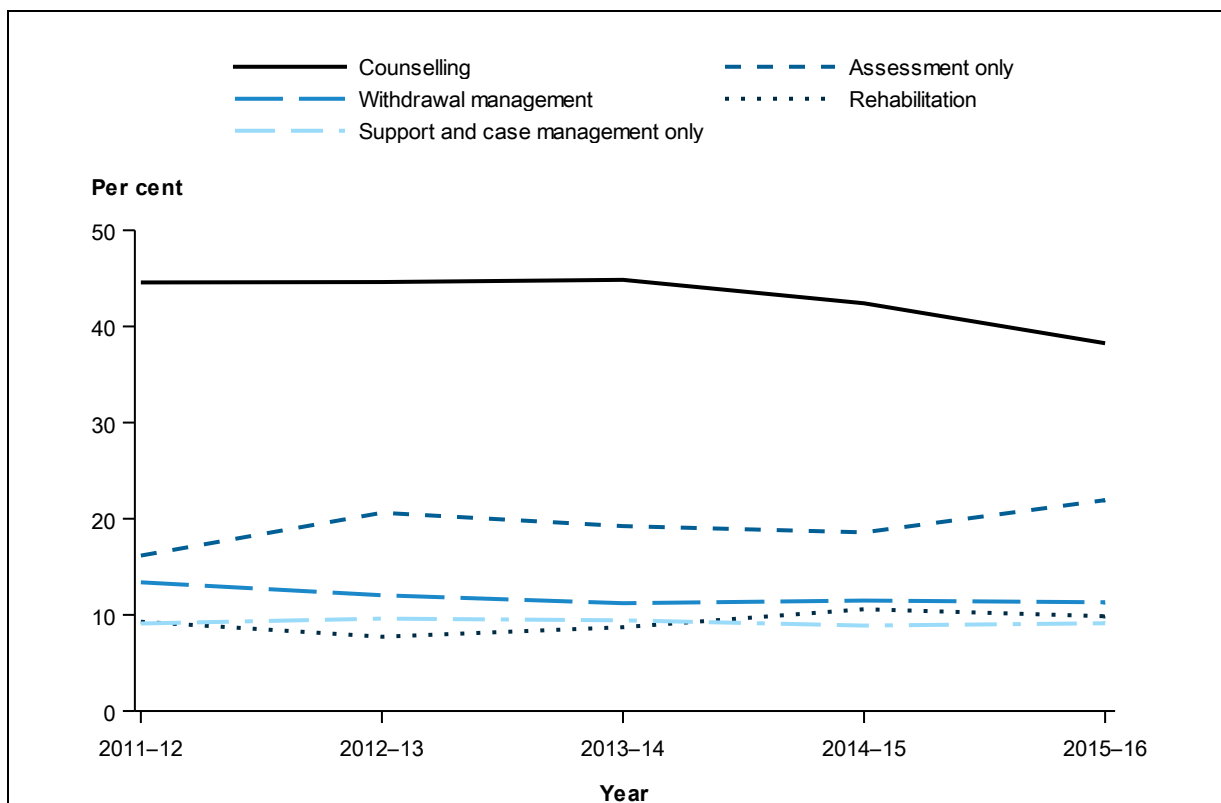


Treatment

The most common source of referral for treatment episodes with amphetamines as the principal drug of concern was self/family (42%), followed by health services (24%), and diversion (18%) (Table SD.61).

In 2015–16, the most common main treatment type for episodes with amphetamines as the principal drug of concern was counselling (38%), followed by assessment only (22%), and withdrawal management (11%). Treatment was most likely to take place in a non-residential treatment facility (68%) (Table SD.60).

Over the 5 years to 2015–16, the proportion of episodes where counselling was the main treatment type for amphetamines as the principal drug of concern fell from 45% to 38% (Figure 4.11; Table SD.58).



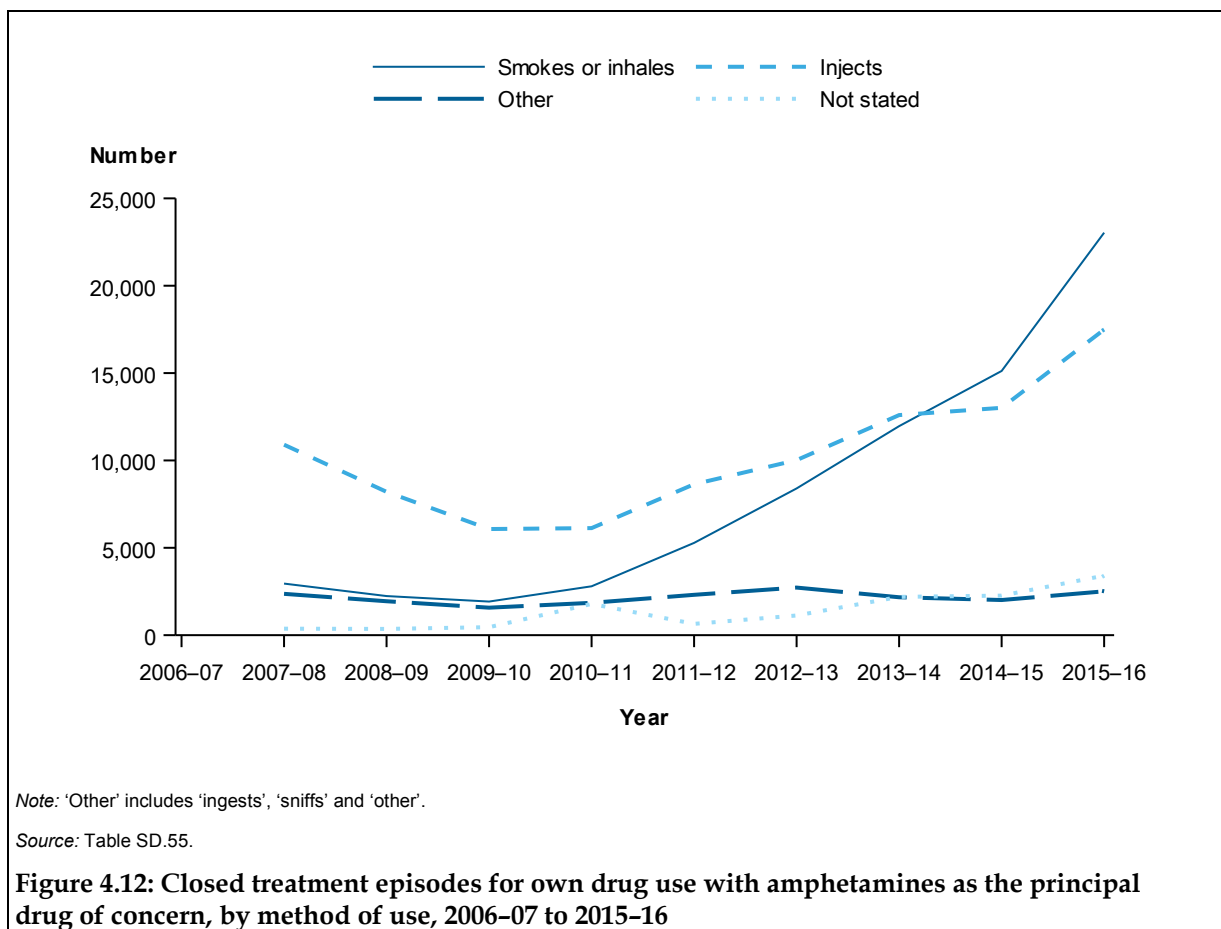
Source: Table SD.58.

Figure 4.11: Closed treatment episodes with amphetamines as the principal drug of concern, by the top 5 treatment types received, 2011-12 to 2015-16

Just over half (52%) of closed episodes with amphetamines as the principal drug of concern lasted less than 1 month (23% ended within 1 day, and were mostly for assessment only) (Table SE.25). The median duration of episodes was 4 weeks (28 days) (Table SE.23). Episode duration varied widely depending on the main treatment type—episodes with a main treatment type of counselling had a median duration of just over 8 weeks (57 days), episodes with withdrawal management ended within 1 week (7 days), and information and education only lasted 1 day (Table SD.64).

Over 2 in 5 (62%) closed episodes with amphetamines as the principal drug of concern ended with an expected cessation. Expected cessations were most common for episodes where self/family was the referral source (41%). Almost one-quarter (24%) of episodes ended unexpectedly (Table SD.61).

Over the 5 years to 2015-16, the number of episodes for clients smoking/inhaling amphetamines increased, with clients 4 times as likely to smoke/inhale amphetamines in 2015-16 compared to 2011-12 (Figure 4.12). Injecting as a method of use for amphetamines rose in 2011-12, which may be attributed to a few patterns arising from an increase in the availability of crystal methamphetamines, as well as an increase in treatment episodes, and for injecting clients who might have been using amphetamines and heroin interchangeably (AIHW 2015).



4.4 Heroin

Box 4.6: Heroin

Heroin is 1 of the opioid drugs, which are strong pain-killers with addictive properties. Short-term side effects of use include pain relief and feelings of euphoria and wellbeing, while long-term effects can include lowered sex drive and infertility (for women), along with risk of overdose, coma, and death (ADCA 2013).

Heroin users seeking treatment can take part in a withdrawal program (also called detoxification), an abstinence-based treatment (for example, residential rehabilitation in a therapeutic community), or attend an opioid maintenance substitution program (O'Brien 2004).

Results from the 2016 National Drug Strategy Household Survey showed that:

- 1.3% of people in Australia aged 14 and over had used heroin in their lifetime and 0.2% had used it in the previous 12 months
- there was no significant change in the proportion of people using heroin between 2013 and 2016 (AIHW 2017).

In 2015–16, heroin was a drug of concern (principal or additional) in 8% of closed treatment episodes, and was reported in 6% of episodes, making it the 4th most common principal drug of concern (11,003 closed treatment episodes, and 5% of clients) (Figure 4.3; tables SC.5 and SD.8).

This was consistent for both Indigenous (4%) and non-Indigenous clients (5%) (Table SC.7). In more than half (52%) of episodes with heroin as the principal drug of concern, the client reported additional drugs of concern, most commonly amphetamines (23%) and cannabis (19%) (tables SD.6 and SD.7).

Injecting was the most common method of use in most episodes where the principal drug of concern was heroin (81% of episodes) (Table SD.87). In almost 3 in 5 (61%) episodes, the client reported they had injected drugs in the previous 3 months, while 13% reported they last injected 3–12 months ago (injecting status was not reported for 7% of episodes) (Table SD.88).

Heroin was the principal drug of concern for 1 in 14 clients (7%) who received treatment during both 2014–15 and 2015–16 (Table SC.36).

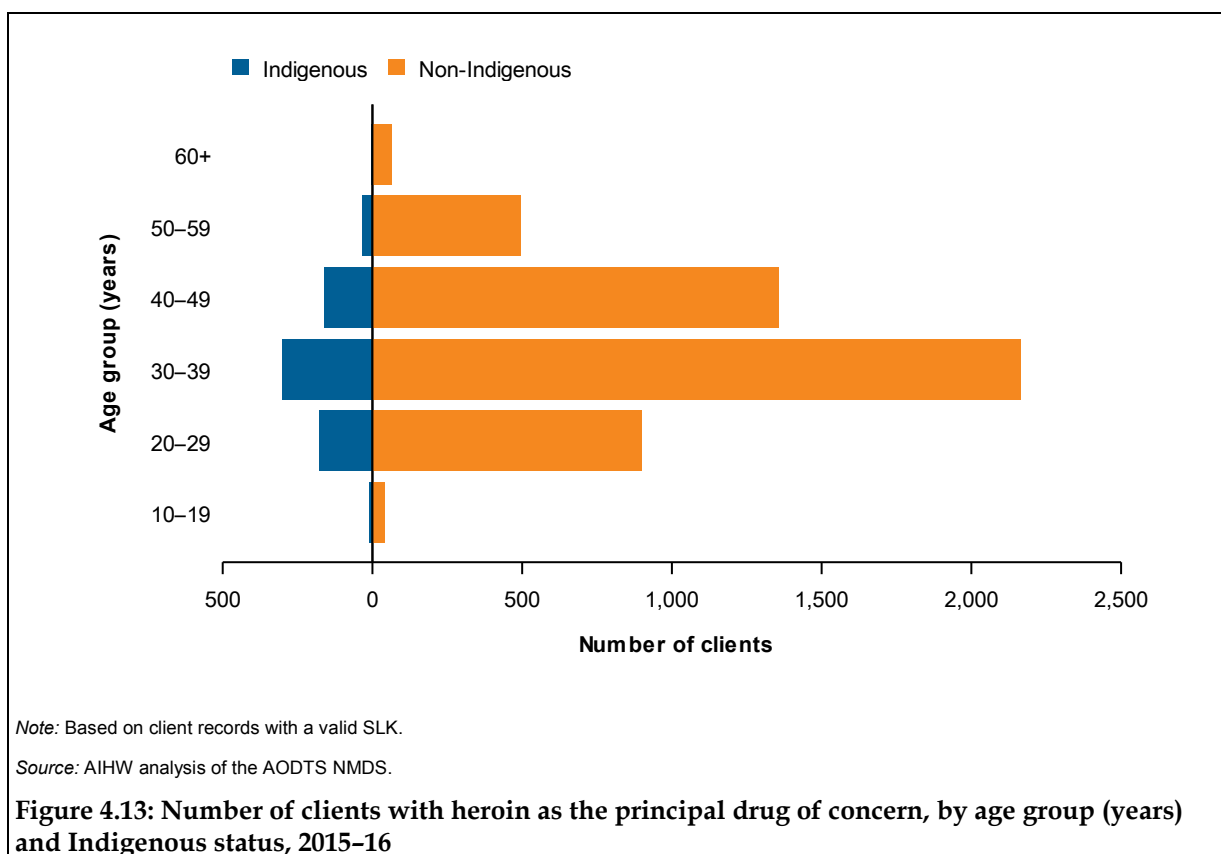
Of the clients receiving treatment across all 3 collection years from 2013–14 to 2015–16, 1 in 10 clients (10%) sought treatment for heroin as a main drug concern (Table SC.31).

Over the 5 years to 2015–16, the proportion of episodes where heroin was the principal drug of concern fell steadily (from 9% to 6%) (Table SD.2).

Client demographics

Where heroin was the principal drug of concern, 68% of clients were male, and 12% were Indigenous (tables SC.5 and SC.7). Indigenous Australians (146 per 100,000 population) were more likely to have received treatment than non-Indigenous Australians (29 per 100,000 population) (Table SC.26).

Clients with heroin as their principal drug of concern were most likely to be aged 30–39 (43%), followed by those aged 40–49 (26%), and those aged 20–29 (19%) (Table SC.7). Indigenous clients whose principal drug of concern was heroin tended to be younger—more than two-thirds of clients (67%) were aged 20–39, over 2 in 5 (43%) were aged 30–39, and over one-quarter (26%) of clients were aged 20–29 (Figure 4.13).



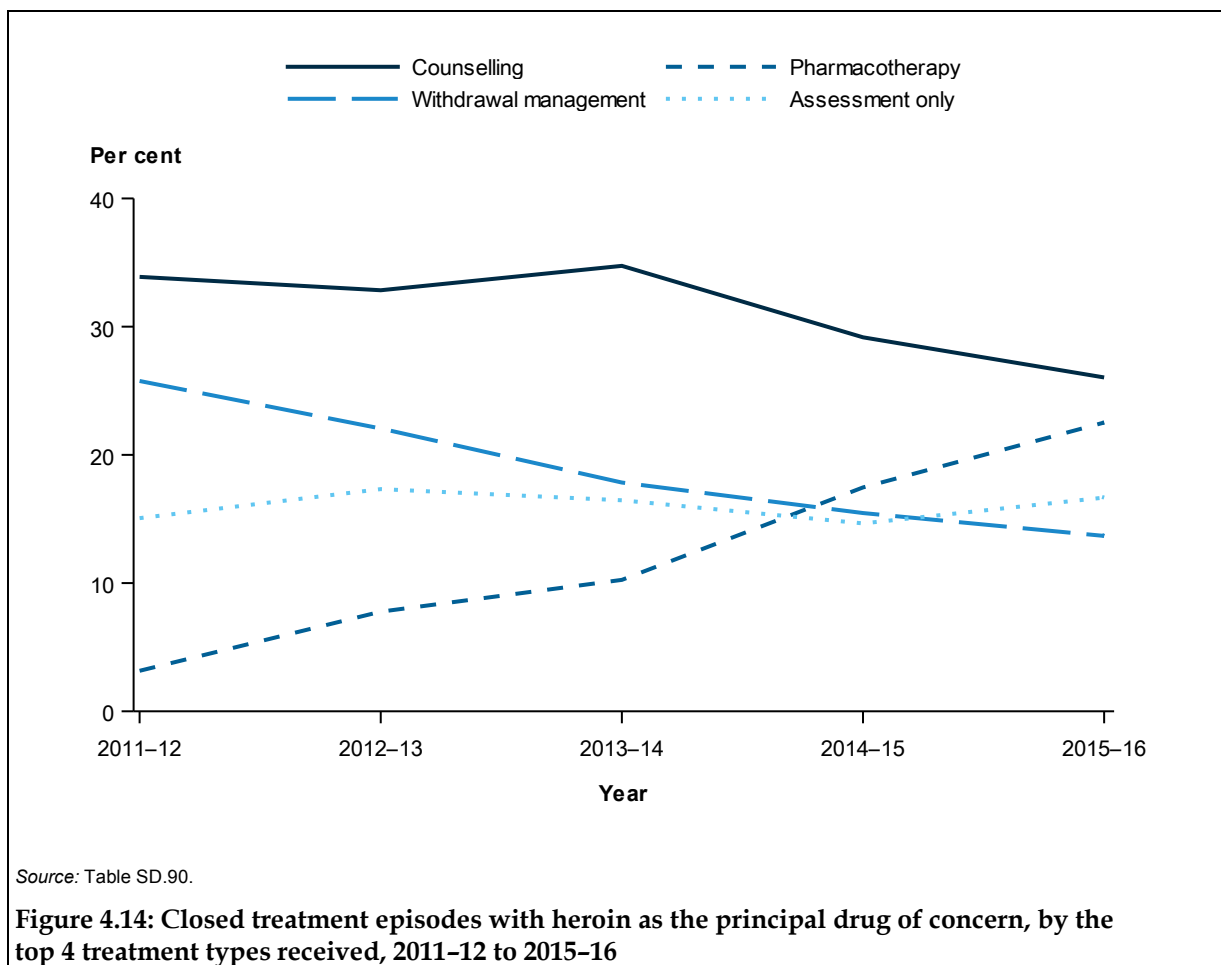
Treatment

The most common source of referral for treatment episodes with heroin as the principal drug of concern was self/family (52%), followed by a health service (24%), and diversion programs (10%) (Table SD.85).

The most common main treatment types were counselling (26%), followed by pharmacotherapy (23%), and withdrawal management (14%) (Table SD.90). Note this collection does not systematically cover replacement therapies.

Treatment episodes with heroin as the principal drug of concern were most likely to take place in a non-residential treatment facility (76%) (Table SD.92).

Over the 5 years to 2015–16, the proportion of episodes with withdrawal management as the main treatment type for the principal drug of concern of heroin fell from 26% to 14% (Figure 4.14). The increase in the proportions for pharmacotherapy is mostly due to changes in the AODTS NMDS reporting specifications, to allow pharmacotherapy to be reported as a primary treatment, in combination with some other form of treatment, for the first time in 2011–12.



Almost half (46%) of the episodes where heroin was the principal drug of concern lasted less than 1 month (20% ended within 1 day, and were mostly for the main treatment types of assessment only, counselling, and withdrawal management) (Table SE.25).

The median duration of episodes with heroin as the principal drug of concern was just over 5 weeks (39 days). Episodes with counselling and support and case management as the main treatment lasted about 10 weeks (68 days and 72 days, respectively), while episodes with withdrawal management treatment lasted about 1 week (6 days) (Table SD.96).

More than half (55%) of closed episodes with heroin as the principal drug of concern ended with an expected cessation, and expected cessations were most common where the main treatment type was information and education only (76%). This is because this treatment type is usually completed within a day (Table SD.93).

4.5 Selected other drugs

A number of other drugs make up a smaller proportion of overall treatment services. These drugs may be less prominent in treatment services because they are less common, or users are less likely to seek treatment. Information on nicotine, ecstasy, benzodiazepines, and pharmaceuticals is combined in this section, due to the size of the population using the drug and/or harms associated with use of that drug (see Box 4.1).

Results from the National Drug Strategy Household Survey showed that in 2016:

- almost 1 in 7 Australians were current smokers, and 1 in 8 were daily smokers
- while smoking rates have been on a long-term downward trend, for the first time in over 2 decades, the daily smoking rate among people aged 14 and older did not significantly decline between 2013 to 2016 (from 13% to 12%)
- 2% of Australians aged 14 and over used ecstasy in the previous 12 months
- ecstasy use did not significantly change from 2.5% in 2013 to 2.2% in 2016
- Just under 1 in 20 (4.8%) Australians had misused a pharmaceutical in the last 12 months (pain-killers/opiates, tranquillisers, steroids, or methadone/buprenorphine) (AIHW 2017).

Box 4.7: Drug descriptions

Nicotine

Nicotine is the stimulant drug in tobacco smoke. It is highly addictive and causes dependency (ADCA 2013). Tobacco use (9%) was the highest risk factor contributing to the total burden of disease and injury in Australia in 2011 (AIHW 2016). The health effects of smoking include premature death and tobacco-related illnesses such as cancer, chronic obstructive pulmonary disease, and heart disease.

Ecstasy

Ecstasy is the popular street name for a range of drugs said to contain the substance 3, 4 methylenedioxymethamphetamine (MDMA), an entactogenic stimulant with hallucinogenic properties. Ecstasy is usually sold in tablet or pill form, but is sometimes found in capsule or powder form. The short-term effects of ecstasy include euphoria, feelings of wellbeing and closeness to others, and increased energy. Harms include psychosis, heart attack, and stroke. Little is known about the long-term effects of ecstasy use, but there is some research linking regular and heavy use of ecstasy to memory problems and depression (ADCA 2013).

Benzodiazepines

Benzodiazepines are depressant drugs—they slow down the activity of the central nervous system, and the speed of messages going between the brain and the body. Formerly known as ‘minor tranquillisers’, benzodiazepines are most commonly prescribed by doctors to relieve stress and anxiety, and to aid sleep. They are a drug of dependence, and are associated with fatal and non-fatal overdose among opioid users. Some people use benzodiazepines illegally to become intoxicated or to come down from the effects of stimulants, such as amphetamines or cocaine (ADF 2013).

Pharmaceuticals

Pharmaceuticals are drugs that are available from a pharmacy—over the counter or by prescription—which may be subject to misuse (MCDS 2011). In the 2015–16 AODTS NMDS report, 10 drug types were identified as making up the group ‘pharmaceuticals’ for the purposes of this analysis: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

Further information corresponding to the Australian Standard Classification of Drugs of Concern (ASCDC) codes and classifications is in Appendix A.

The following selected drugs of concern were more likely to be reported as an additional drug of concern rather than a principal drug of concern (tables 4.1 and SD.8). Nicotine was reported as a principal drug of concern in only 2% of treatment episodes, but in 18% of episodes as an additional drug of concern. Clients seeking treatment for ecstasy were younger – aged 10–29 (94%) – and were more likely to be male (82%). Almost 8 in 10 (77%) clients seeking treatment for benzodiazepines were aged over 30 and more than half were female. Where pharmaceuticals were the principal drug of concern, clients were more likely to be aged 30 and over (79%), and male (59%) (Table 4.1).

Table 4.1: Summary characteristics of other selected drugs of concern, 2015–16 (%)

	Nicotine	Ecstasy	Benzodiazepines	Pharmaceuticals ^(a)
Sex^(b)				
Male	60.5	81.6	49.9	58.5
Female	39.5	18.4	50.1	41.4
Indigenous status^{(b) (c)}				
Indigenous	14.9	3.1	7.1	11.3
Non-Indigenous	70.1	82.3	89.3	83.9
Age^(b)				
10–19	13.5	37.2	3.7	1.9
20–29	23.2	56.8	19.1	19.1
30–39	21.7	4.5	30.5	35.7
40–49	18.5	1.1	24.1	25.6
50+	23.1	0.4	22.7	17.7
Drugs of concern				
Principal drug of concern	2.4	0.6	0.9	5.2
Additional drug of concern	17.8	1.8	4.5	9.0
Referral to treatment				
Self/family	27.1	12.8	42.8	44.7
Health service	39.1	9.2	38.2	39.4
Corrections	3.2	3.1	2.6	4.6
Diversion	24.8	72.6	6.7	4.7
Other	5.8	2.2	9.7	6.6
Main treatment type				
Counselling	31.2	18.2	29.7	22.3
Information and education only	16.2	48.9	4.5	3.3
Assessment only	28.2	21.8	15.9	18.9
Withdrawal management	11.8	1.1	23.3	14.7
Other ^(d)	12.6	9.8	26.7	22.4

(continued)

Table 4.1 (continued): Summary characteristics of other selected drugs, 2015–16 (%)

	Nicotine	Ecstasy	Benzodiazepines	Pharmaceuticals ^(a)
Treatment setting				
Non-residential treatment facility	65.0	88.0	67.2	74.6
Residential treatment facility	2.7	2.2	17.2	11.8
Other ^(e)	32.1	9.8	15.6	13.6
Treatment completion				
Expected cessation	70.1	87.2	57.1	53.2
Unexpected cessation	14.6	7.1	16.4	17.2
Other ^(f)	6.9	5.6	26.6	29.5
Median duration	14 days	1 day	17 days	22 days

(a) Includes codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

(b) Based on valid SLK client data.

(c) The proportion of clients for Indigenous status may not sum to the total, due to missing or not reported data.

(d) Includes support and case management only, pharmacotherapy, other and rehabilitation.

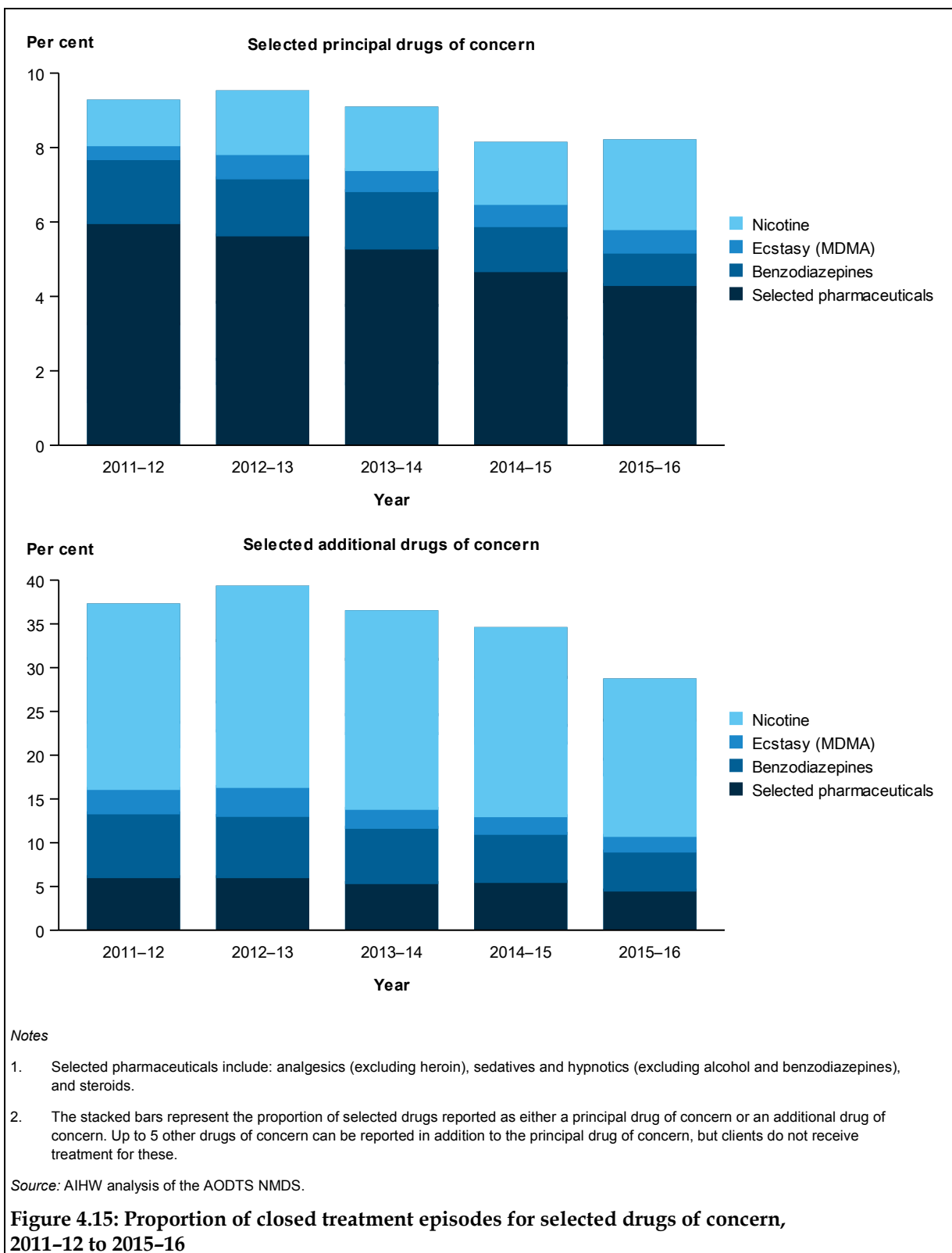
(e) Includes where treatment is delivered in the client's own home or usual place of residence or in an outreach setting.

(f) Includes administrative cessation.

Sources: Figure 4.3, Tables SC.5–7, SD.66, SD.69, SD.73, SD.78–79, SD.98, SD.106, SD.108–110, SD.114, SD.122, SD124–126.

The proportion of episodes with nicotine, ecstasy, and benzodiazepines as the principal drug of concern remained stable at 1%–2% per year since 2011–12, but pharmaceutical drugs as a group peaked at 8% in 2011–12, falling to 5% in 2015–16 (Figure 4.15; Table SD.2).

Over the 5 years to 2015–16, closed treatment episodes for additional drugs of concern varied—ecstasy fell from 3% to 2%, and benzodiazepines fell from 7% to 4%. Nicotine fluctuated, rising from 21% to 23% in 2013–14, then falling to 18% in 2015–16 (tables SD.9 and SD.146).



Nicotine

In 2015–16, nicotine was a principal drug of concern in just 2% of episodes (4,688 closed episodes), but an additional drug of concern in 18% of episodes (35,312 closed episodes) (Figure 4.3). Since 2006–07, the proportion of episodes with nicotine as the principal drug has remained stable at 1%–2% (Table SD.2). Possible reasons for the low proportion of episodes in which nicotine was the principal drug include the wide availability of support and treatment for nicotine use in the community, such as through general practitioners, pharmacies, helplines, or web services. People might also view AOD treatment services as most appropriate for drug use that is beyond the expertise of general practitioners. But therapy to quit smoking is becoming an integral part of some AOD services as a parallel treatment with other drugs of concern.

Client demographics

Where nicotine was a principal drug of concern, 61% of clients were male, and 15% were Indigenous Australians (tables SC.5 and SC.7). Over one-third of clients with nicotine as a principal drug of concern were aged 10–29 (37%), and 23% were aged over 50 (tables 4.1 and SC.6).

Nicotine was more commonly reported as an additional drug of concern (18%) – the most commonly reported principal drugs of concern in combination with nicotine as an additional drug of concern were alcohol (31%) and cannabis (28%) (Figure 4.3; tables SD.7 and SD.8).

Treatment

The most common source of referral for treatment episodes where nicotine was the principal drug of concern was a health service (39%), followed by self/family (27%), and police or court diversion programs (25%) (Table 4.1).

Counselling (31%), assessment only (28%), and information and education only (16%) were the most common main treatment types (tables 4.1 and SD.74).

Treatment episodes where nicotine was the principal drug of concern were most likely to take place in a non-residential treatment facility (65%) (Table SD.76).

Two-thirds (62%) of episodes with nicotine as the principal drug lasted less than 1 month (35% ended within 1 day, and were mostly for counselling) (Table SE.25). The median duration of episodes with nicotine as the principal drug of concern was 14 days (tables 4.1 and SD.79).

Almost three-quarters (70%) of episodes with nicotine as the principal drug of concern ended with an expected cessation, while less than one-fifth (15%) ended unexpectedly. Expected cessations were most common where the main treatment type was assessment only (33%) (Table SD.78).

Ecstasy

Ecstasy was a principal drug in less than 1% of episodes (1,254 of closed episodes), and an additional drug of concern in 2% (3,547) of closed episodes in 2015–16 (tables SD.7 and SE.9).

The proportion of episodes with ecstasy as a principal drug has remained stable up to 1% of all closed treatment episodes since 2006–07. But as an additional drug of concern, it decreased from 6% of episodes in 2008–09 to 2% in 2015–16 (tables 4.1 and SD.9).

Client demographics

Where ecstasy was the principal drug of concern, over 8 in 10 (82%) clients were male, and 3% were Indigenous. Over half of the clients (57%) with ecstasy as a principal drug of concern were aged 20–29, and almost 2 in 5 (37%) were aged 10–19 (tables 4.1, SD.115 and SD.116).

Ecstasy was more likely to be reported as an additional drug of concern – the most common principal drugs of concern that were reported in combination with ecstasy as an additional drug of concern were alcohol (37%) and cannabis (25%) (Figure 4.3; Table SD.7).

Treatment

In almost three-quarters (73%) of treatment episodes where ecstasy was the principal drug of concern, the client's source of referral was from police and court diversion (tables 4.1 and SD.125).

The most common main treatment type for episodes where ecstasy was the principal drug was information and education only (49%), followed by assessment only (22%), and counselling (18%) (Table SD.121).

Treatment episodes where ecstasy was the principal drug of concern were most likely to take place in a non-residential treatment facility (88%) (Table SD.124).

Almost three-quarters (72%) of episodes with ecstasy as the principal drug lasted less than 1 month (57% ended within 1 day) (Table SE.25). The median duration of episodes with ecstasy as the principal drug of concern was 1 day (Table SD.127).

Almost 9 in 10 (87%) episodes with ecstasy as the principal drug of concern ended with an expected cessation, while 7% ended unexpectedly. Expected cessations were most common where the main treatment type was information and education only (54%) (Table SD.125).

Benzodiazepines

In 2015–16, benzodiazepines were a drug of concern (principal or other) in 5% of closed episodes (as the principal drug in 1% or 1,729 episodes, or as an additional drug in 6% or 8,858 episodes) (Figure 4.3; Table 4.1). In the 10 years from 2006–07, the proportion of episodes with benzodiazepines as the principal drug only changed by 1 percentage point (Table SD.2).

Client demographics

Where benzodiazepines were the principal drug of concern, half (50%) of the clients were female and 7% were Indigenous. Over half of the clients (55%) with benzodiazepines as a principal drug of concern were aged 30–49, and almost one-quarter (23%) were aged 50 and over (Table 4.1).

Benzodiazepines were more likely to be an additional drug of concern – the most common principal drugs of concern in combination with benzodiazepines as an additional drug of concern were alcohol (18%), cannabis (17%), and nicotine (13%) (Figure 4.3).

Treatment

The most common source of referral for treatment episodes with benzodiazepines as the principal drug of concern was self/family (43%), followed by a health service (38%) (Table 4.1).

The most common main treatment type for episodes with benzodiazepines as the principal drug of concern was counselling (30%), followed by withdrawal management (23%), and assessment only (16%) (tables 4.1 and SD.106).

Treatment episodes were most likely to take place in a non-residential treatment facility (67%), followed by a residential treatment facility (17%). Almost all (91%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table SD.108).

Where benzodiazepines were the principal drug of concern, 3 in 5 (60%) episodes lasted less than 1 month, and 21% of episodes lasted up to 3 months (Table SE.25). The median duration of episodes with benzodiazepines as the principal drug of concern was over 2 weeks (17 days) (Table SD.111).

Over half (57%) of episodes with benzodiazepines as the principal drug of concern ended with an expected cessation, while 1 in 6 (16%) ended unexpectedly. Expected cessations were more common for episodes where the main treatment type was withdrawal management (27%) or counselling (22%) (Table SD.109).

Pharmaceuticals

Box 4.8: Pharmaceuticals

As a group, pharmaceuticals are not listed as a broad drug group in the Australian Standard Classification of Drugs of Concern (ASCDC) classification – 10 drug groups make up the group ‘pharmaceuticals’ for the purposes of this report: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

In 2015–16, pharmaceuticals were the principal drug of concern in 5% of episodes (Table 4.1). Over the 10-years from 2006–07, the proportion of treatment episodes with a pharmaceutical drug as the principal drug of concern rose from 6% in 2006–07 to 8% in 2011–12, and then fell to 5% in 2015–16. The proportions of treatment episodes for morphine and benzodiazepines have been decreasing over the 10-year period, while the proportions for codeine, methadone, oxycodone, and buprenorphine have been increasing (Table SD.146).

Previously, benzodiazepines represented the largest proportion of closed episodes for a single drug type within the pharmaceutical group (17%), but in 2015–16 reporting increased for methadone (19%), morphine (14%), codeine (14%), and oxycodone (10%) (Table SD.146).

Client demographics

Where pharmaceuticals were the principal drug of concern, over half (59%) the clients were male, and around 1 in 10 were Indigenous (11%). Female clients were more likely to report individual pharmaceutical drug types. In 2015–16, a higher proportion of female clients (53%) reported codeine as their principal drug of concern, and women were slightly more likely than males to report benzodiazepines as their principal drug of concern (50%) (tables 4.1 and SD.146).

The most common age group for clients seeking treatment for pharmaceuticals as a principal drug of concern were aged 30–39 (36%), followed by clients aged 40–49 (26%), and 20–29 (19%) (Table 4.1).

Pharmaceuticals were more likely to be reported as an additional drug of concern in closed treatment episodes (9%) – the most common principal drugs of concern reported in combination with pharmaceuticals as an additional drug of concern were alcohol (24%), amphetamines (22%), and heroin (18%) (tables 4.1 and SD.147).

Treatment

Almost half of the referrals for treatment episodes where pharmaceuticals were the principal drug of concern were for self/family (45%), followed by a health service (39%) (Table 4.1).

The most common main treatment type for episodes where pharmaceuticals were the principal drug of concern was counselling and other treatments (both 22%), followed by assessment only (18%) (Table 4.1).

In 2015–16, clients with pharmaceuticals as a principal drug of concern were more likely than other clients to have ever injected a drug. In about one-third of episodes (31%), clients reported they last injected within the last 3 months, whereas for all other drugs, clients were more likely to report having never injected (57% of treatment episodes) (Table SD.153).

Over half (54%) of treatment episodes for pharmaceuticals as the principal drug of concern ended with an expected cessation, while 1 in 5 (20%) ended unexpectedly.

In 2015–16, expected cessations were more common in the pharmaceutical group for episodes where the treatment was for benzodiazepines (22%), while the highest proportion for unexpected cessation was for morphine (17%) (tables 4.1 and SD.150).

5 Treatment provided

There are a number of treatment types available to assist people with problematic drug use in Australia. Most aim to reduce the harm of drug use, while others use a structured drug-free setting with abstinence-oriented interventions.

This chapter presents information on the treatment types provided by publicly funded AOD treatment agencies in Australia. Information on clients and treatment agencies is included in the AODTS NMDS when a treatment episode provided to a client is closed (see Box 2.1). Treatment is available to help people address their own drug use, and to support the family and friends of people using drugs.

Box 5.1: Treatment provided key facts

In 2015–16:

- counselling was the most common treatment type (36%)
- self/family was the most common source of referral for treatment episodes (37%)
- around 4 in 5 (79%) closed treatment episodes ended within 3 months
- the median duration of closed treatment episodes was 3 weeks (20 days)
- around 2 in 3 (62%) closed treatment episodes had an expected cessation
- most of the treatment episodes provided to clients for their own drug use were for male clients (67%), whereas most clients seeking support for someone else's drug use were female (64%)
- clients seeking support for someone else's drug use were older – over half (57%) were aged 40 and over, compared with over two-thirds (69%) of clients seeking treatment for their own drug use were aged 10–39.

Over the 5-year period to 2015–16:

- the proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management, and assessment only being the most common types of treatment
- the median duration of closed episodes for the client's own drug use decreased from 25 days to 19 days
- the proportion of episodes with an expected cessation decreased from 66% to 62%.

5.1 Characteristics of clients and episodes

In 2015–16, an estimated 133,895 clients received 206,635 treatment episodes from AOD treatment agencies. Most of the clients were seeking treatment for their own drug use – a total of 125,668 clients (or 96% of episodes) – and were more likely to be male (69% of clients). Conversely, clients seeking support for someone else’s drug use were more likely to be female (66%) (tables SC.1, SC.14 and SE.2).

Around 1 in 7 clients who received treatment in 2015–16 were Indigenous Australians – 14% of those receiving treatment for their own drug use, and 11% of those receiving support for someone else’s drug use (Table SC.4).

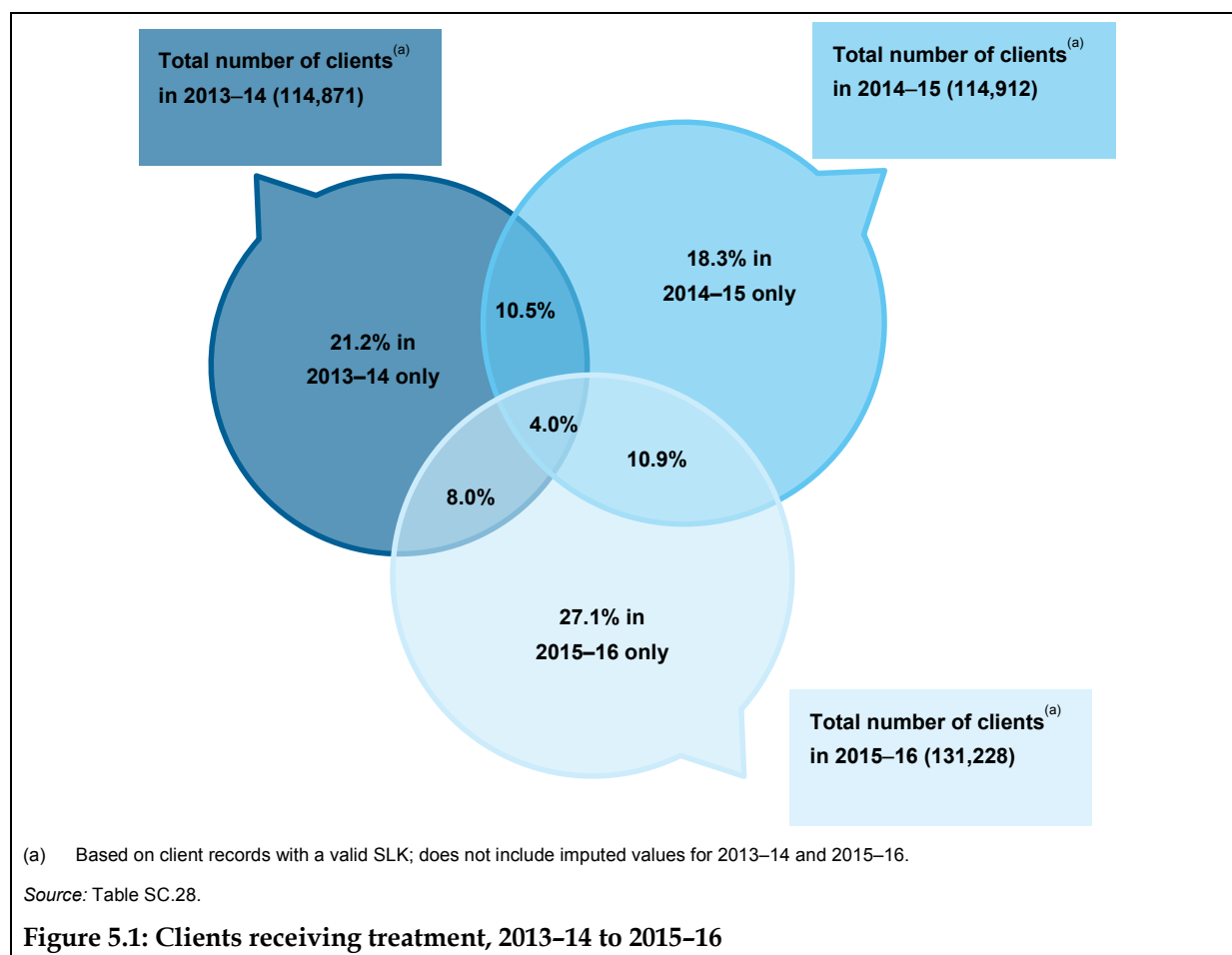
In 2015–16, more than half (55%) of clients seeking treatment were aged 20–39. Clients seeking support for someone else’s drug use were older – over half (57%) were aged 40 and over, compared with just under one-third (31%) of those receiving treatment for their own drug use Table SC.3).

Nationally, in 2015–16, 7 out of 10 (70%) closed treatment episodes were provided in *Major cities*, 17% in *Inner regional* areas and 9% in *Outer regional* areas. Relatively few treatment episodes were provided in *Remote* (2%) or *Very remote* areas (1%).

In 2015–16, most (83%) clients received treatment at a single agency, 13% at 2 agencies, and 3% of clients received treatment at 3 or more agencies (Table SC.23). Nationally, the number of clients presenting to publicly funded AOD services slightly increased between 2014–15 and 2015–16.

A total of 262,734 treatment episodes were provided over 2013–14, 2014–15 and 2015–16. Of these, 27% (71,075 clients) received treatment in 2015–16 only, and 11% (28,704) received treatment in both 2014–15 and 2015–16.

Nationally, over 10,500 (4%) clients remained in treatment over the three year period from 2013–14 to 2015–16 (Figure 5.1).



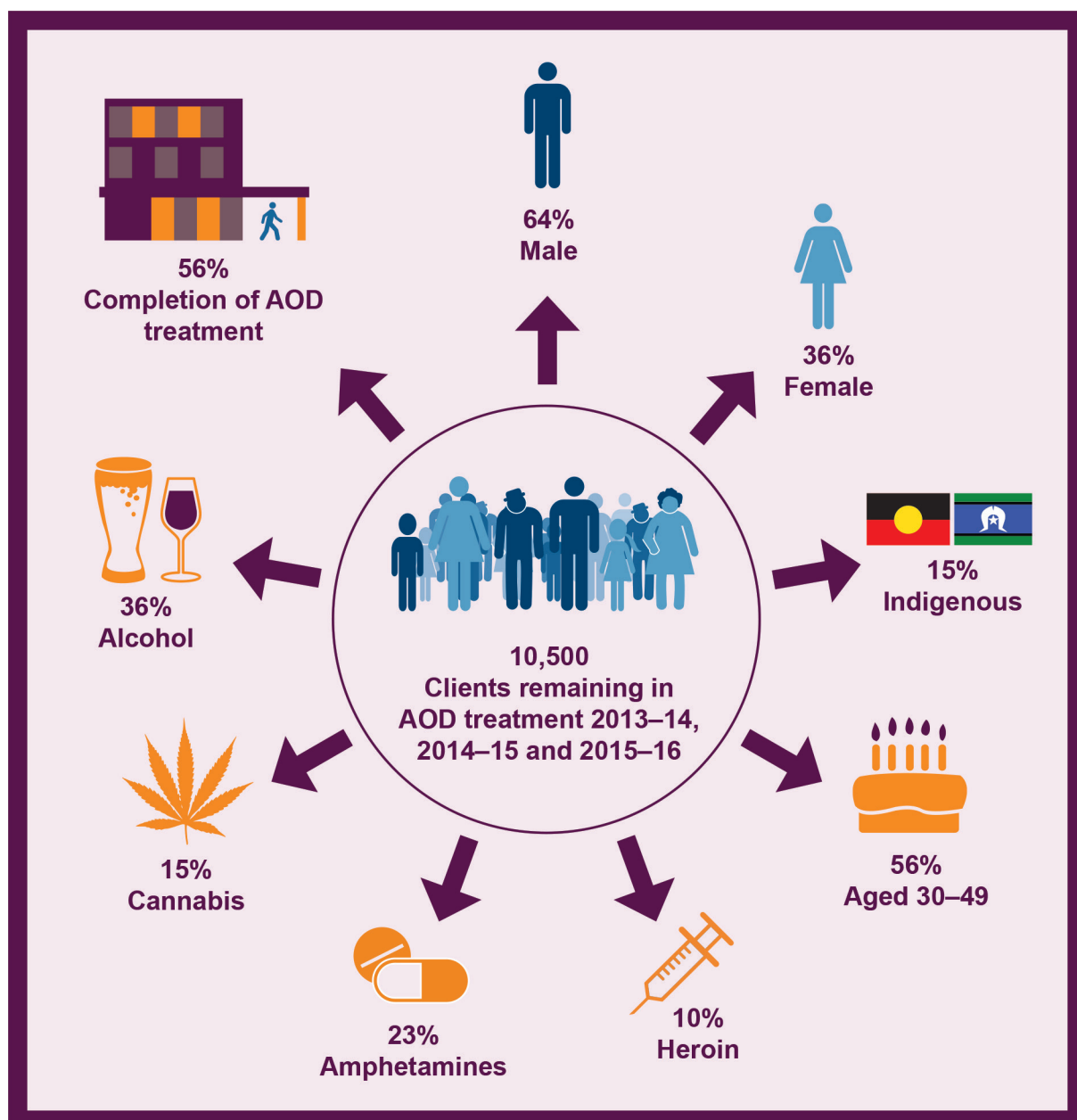
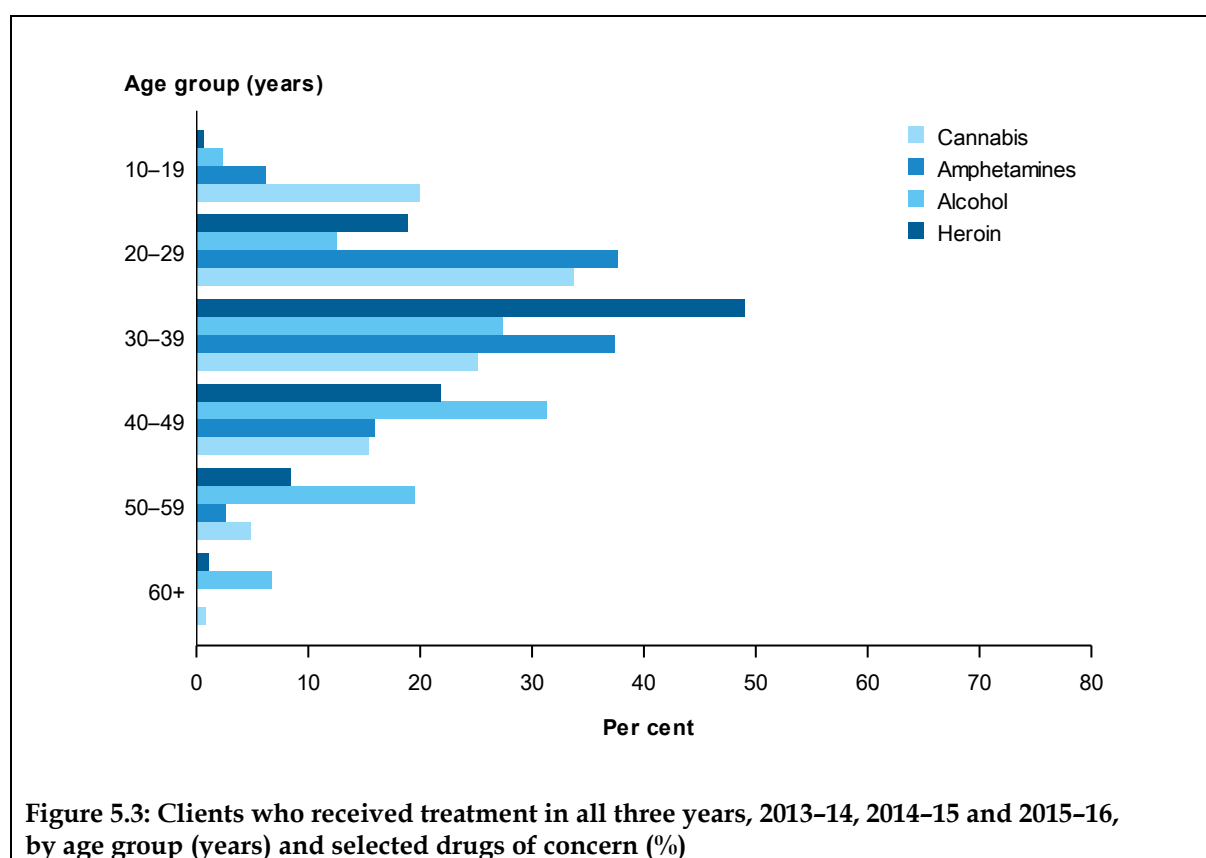


Figure 5.2: Characteristics of clients who received treatment in all three years, 2013–14, 2014–15 and 2015–16

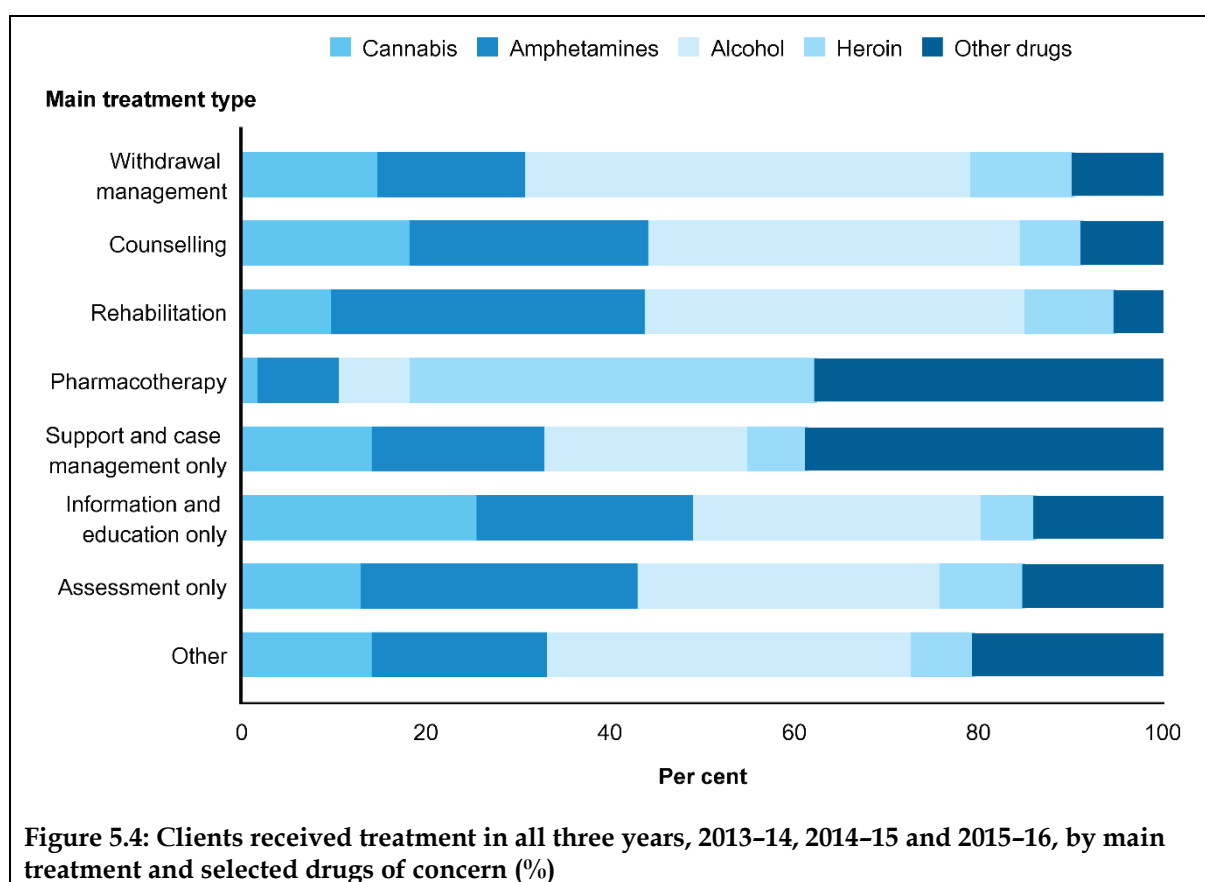
Clients remaining in treatment over the 3-year period from 2013–14 to 2015–16 were:

- more likely to be older where heroin was the principal drug of concern – with 49% aged 30–39, and 22% aged 40–49
- more likely to be younger where cannabis was the principal drug of concern – with 34% aged 20–29, and 20% aged 10–19
- most likely to be aged 20–39 where amphetamines were the principal drug of concern (75%)
- more likely to be older where alcohol was the principal drug of concern – with 2% aged 10–19, and 58% aged 40 or over (58%). Alcohol was the most common principal drug of concern for more than one-third of clients (36%) (Figure 5.3).



For clients remaining in treatment from 2013–14 to 2015–16:

- counselling was the most common treatment type for all clients (38%), followed by withdrawal management (14%)
- rehabilitation was more commonly provided to clients with a principal drug of concern of alcohol (41%) or amphetamines (34%)
- almost half of clients (44%) where heroin was a principal drug of concern, pharmacotherapy was the most common treatment type
- one-quarter (26%) of clients where the principal drug of concern was cannabis, information and education was the most common treatment provided (Figure 5.4; tables SC.30, SC.33).



5.2 Location of treatment

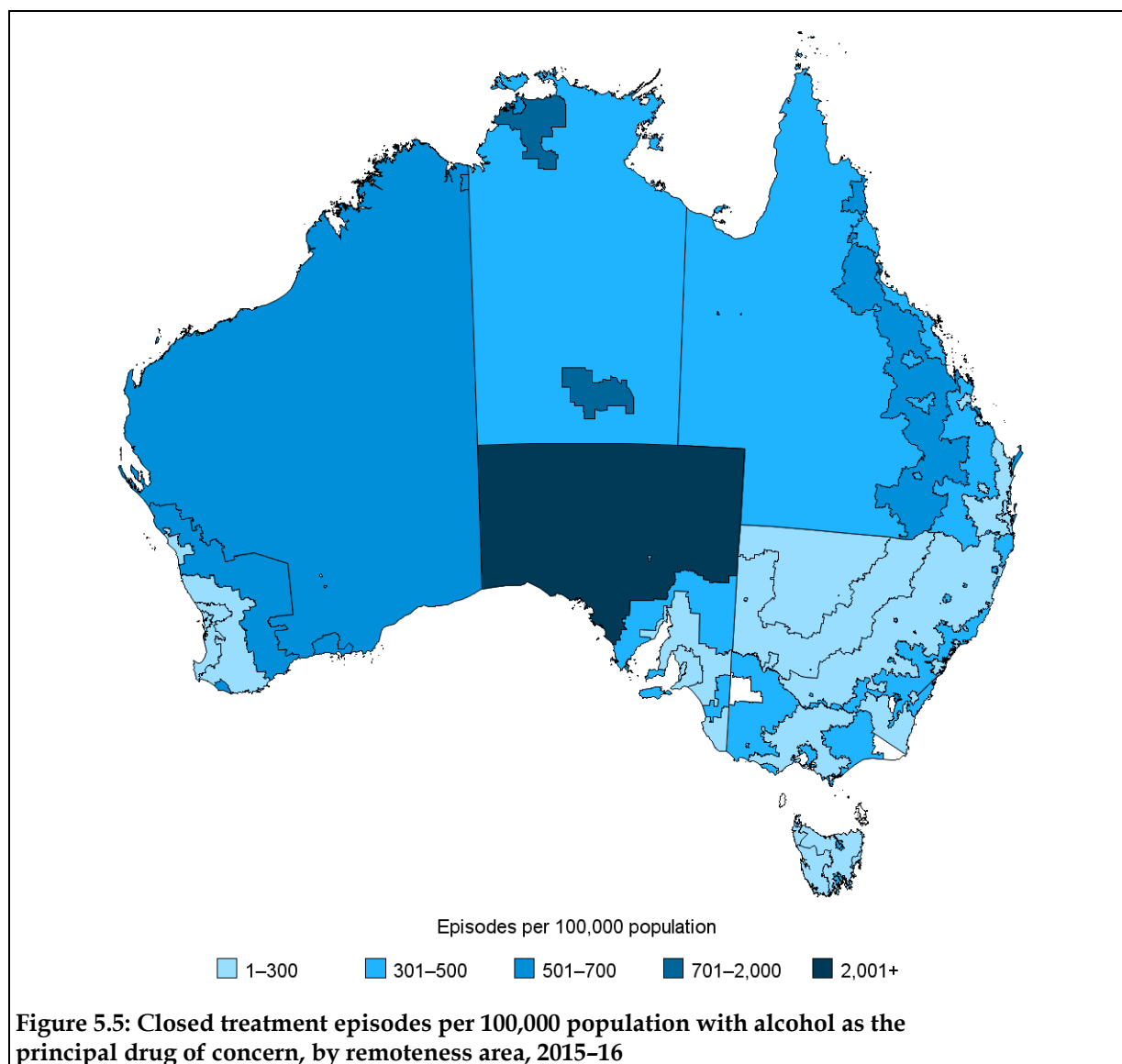
This section focuses on the coverage of treatment services across Australia (using population rates), and how this matches with selected principal drugs of concern.

The proportion of AOD treatment services catering for specific drugs of concern varies with the geographic distribution of the client population, and specific services. This means that access to treatment will vary depending on the drug of concern, treatment type, and specific population group seeking treatment.

Alcohol

Rates of closed treatment episodes for alcohol as a principal drug of concern varied across remoteness areas, and were highest overall in *Remote* areas across Australia.

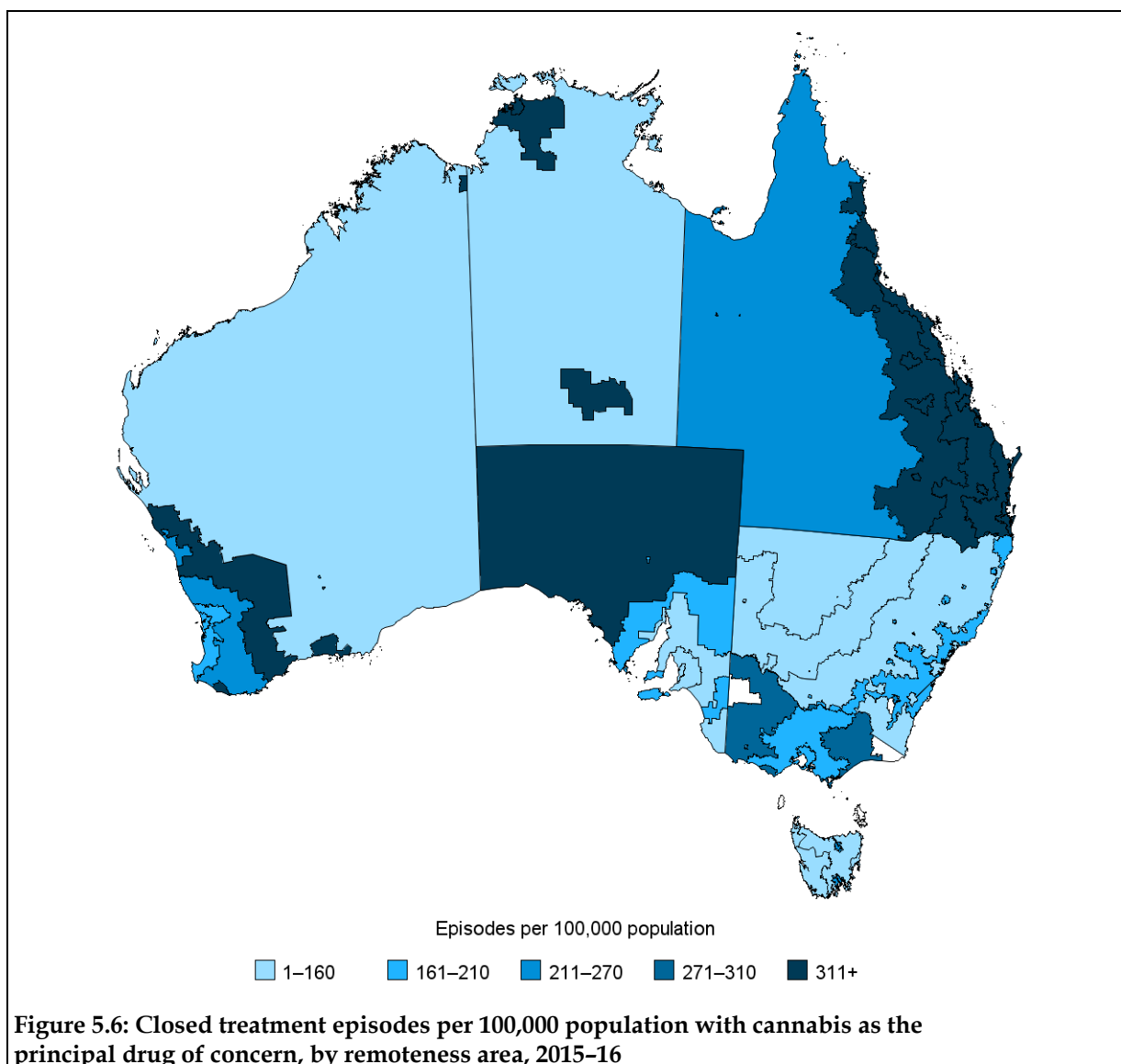
The highest rates for treatment were spread across *Very remote* areas in South Australia, followed by *Remote* and *Very remote* parts of the Northern Territory, and *Remote* regions in Queensland and Western Australia (Figure 5.5; Table SA.10a). Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map.



Cannabis

Rates of closed treatment episodes for cannabis as a principal drug of concern varied across remoteness areas, and were highest overall in *Outer regional* areas across Australia.

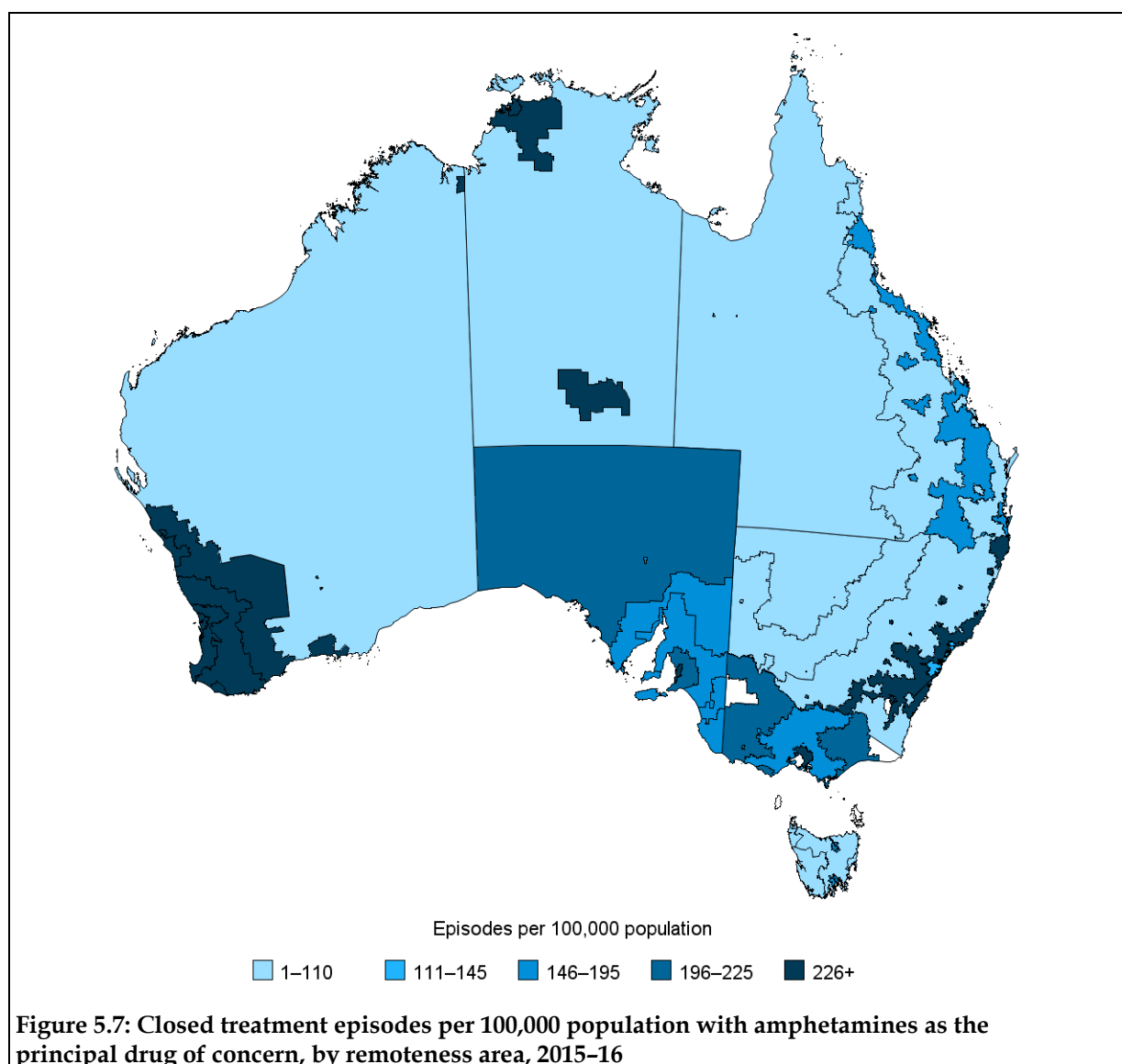
The highest rates for treatment related to cannabis were spread across *Outer regional* and *Remote* areas in Queensland, followed by *Remote* areas of Western Australia, and *Remote* parts bordering South Australia. The Northern Territory displays a concentration of cannabis treatment in *Outer regional* areas, and the *Remote* central desert region (Figure 5.6; Table SA.10b). Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map.



Amphetamines

Rates of closed treatment episodes for amphetamines as a principal drug of concern varied across remoteness areas, and were highest overall in *Major cities* across Australia, followed by *Outer regional* areas.

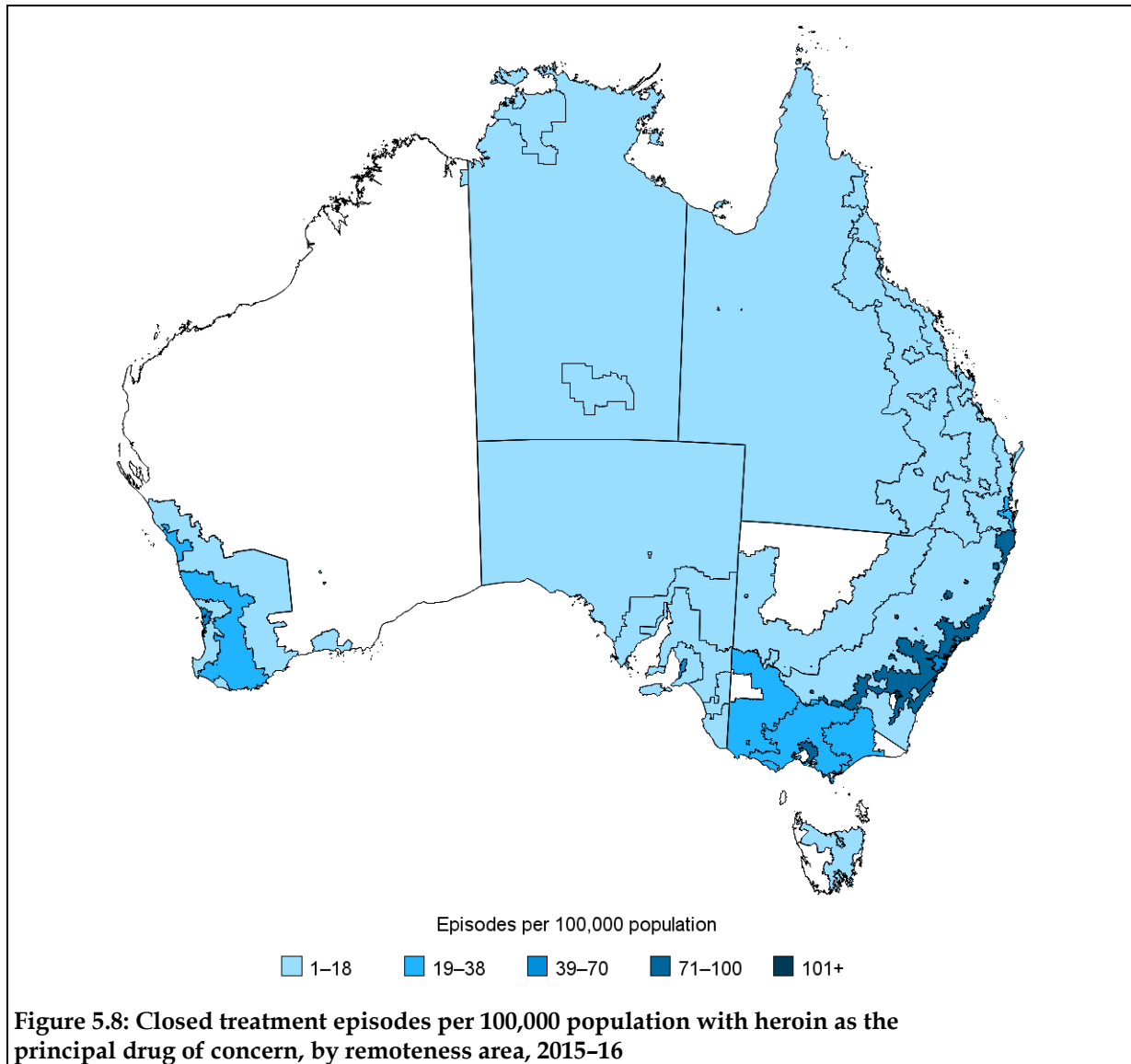
The highest rates for treatment related to amphetamines were spread across *Inner regional* and *Remote* areas of Western Australia, also bordering *Outer regional* parts of Victoria and South Australia. The Northern Territory displays a concentration of amphetamine treatment in *Outer regional* areas, and the *Remote* central desert region (Figure 5.7; Table SA.10c). Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map.



Heroin

Rates of closed treatment episodes for heroin were highest overall in *Major cities* across Australia.

The Australian Capital Territory had the highest rates for heroin treatment in *Major cities*. For *Inner regional* areas, the highest rates for treatment services were in New South Wales, followed by Victoria and Western Australia, which also had high rates in *Outer regional* areas (Figure 5.8; Table SA.10d). Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map.



5.3 Referral to treatment

Nationally, in 2015–16, treatment episodes for self/family referrals were the most common source of referral for both clients receiving treatment for their own drug use (36%), and those receiving support for someone else's drug use (61%). Referral episodes from a health service were also common for both groups (28% and 23%, respectively), while referral episodes from police or court diversion programs accounted for 18% of episodes for clients receiving treatment for their own drug use (Tables ST.13 and ST.14). Clients referred by diversion programs were younger – with 21% of these episodes being for clients aged 10–19, and 36% for clients aged 20–29 (Table SE.16).

Over the 5 years to 2015–16, the proportion of treatment episodes for self/family referrals for clients' own drug use rose from 41% in 2006–07 to 42% in 2013–14, then fell to 36% in 2015–16. Self/family referrals for support for someone else's drug use remained relatively stable (at about 60%) (Table SE.15).

Table 5.1: Closed treatment episodes, by principal drug of concern and source of referral, 2015–16 (%)

Principal drug of concern	Self/family	Health service	Corrections	Diversion	Other	Total
Analgesics						
Codeine	49.4	42.1	0.7	2.7	5.1	100
Morphine	51.4	34.5	5.9	3.9	4.3	100
Buprenorphine	40.9	38.7	10.4	2.7	7.3	100
Heroin	52.3	24.2	7.6	10.0	5.9	100
Methadone	39	45	8	4	6	100
<i>Total analgesics</i>	<i>49.3</i>	<i>31.1</i>	<i>6.6</i>	<i>7.2</i>	<i>5.9</i>	<i>100</i>
Sedatives and hypnotics						
Alcohol	41.4	36.3	5.0	8.3	8.9	100
Benzodiazepines	42.8	38.2	2.5	6.8	9.7	100
<i>Total sedatives and hypnotics</i>	<i>41.5</i>	<i>36.3</i>	<i>4.9</i>	<i>8.3</i>	<i>8.9</i>	<i>100</i>
Stimulants and hallucinogens						
Amphetamines	42.2	24.4	8.0	18.3	7.0	100
Ecstasy	12.8	9.3	3.1	72.6	2.2	100
Cocaine	36.1	18.0	10.9	27.1	0.1	100
Nicotine	27.0	39.1	3.2	24.8	5.8	100
<i>Total stimulants and hallucinogens</i>	<i>39.9</i>	<i>25.2</i>	<i>7.5</i>	<i>20.6</i>	<i>6.8</i>	<i>100</i>
Cannabis	27.5	23.2	6.2	35.9	7.1	100
Volatile solvents	11.9	32.0	3.8	17.4	35.0	100

Source: Table SD.17.

In 2015–16, the source of referral varied according to clients' principal drugs of concern. Self/family were the most common source of referral episodes for clients receiving treatment for the principal drug of heroin (52%), alcohol (41%), and amphetamines (42%) (Table 5.1). Where cannabis was the principal drug of concern, diversion (36% of episodes) was the most common source of referral, followed by self/family referrals (28% of episodes). Clients receiving treatment for alcohol as their principal drug of concern were less likely to be

referred through diversion (8.3% of episodes) and more likely to be referred from a health service (36% of episodes), when compared with clients receiving treatment episodes for heroin (24%), amphetamines (24%), or cannabis (23%). Around 7 in 10 (73%) treatment episodes for clients whose principal drug of concern was ecstasy were referred to treatment through police or court diversion programs (see Chapter 4 for further information).

Over the 5 years to 2015–16, the overall proportion of self/family referrals rose from 41% in 2011–12 to 42% in 2013–14, but fell to 36% in 2015–16 (Table SD.17).

Episodes where alcohol was the principal drug of concern also had a decrease in self/family as the source of referral, from 42% to 41% since 2011–12. The proportion of episodes where the client was referred by diversion rose from 15% in 2011–12 to 18% in 2015–16, with high proportions of diversion referrals for cannabis over this period (26%–36%). Over the same period, the proportion for referral episodes from health services has remained stable (28%) (Table SD.17).

5.4 Duration of treatment

In 2015–16, around 4 in 5 (79%) closed episodes ended within 3 months (79% for clients receiving treatment for their own drug use, and 80% for someone else's drug use). Over the 5 years to 2015–16, the proportion of episodes for clients' own drug use that ended within 3 months remained fairly stable (around 79%) (Table SE.21).

Nationally, the median duration of closed episodes was just under 3 weeks (19 days) for clients' own drug use, and just over 4 weeks (30 days) for clients receiving support for someone else's drug use. The median duration of closed episodes for clients' own drug use fell slightly over the 5 years – from 25 days in 2011–12 to 19 days in 2015–16 (Table SE.22).

5.5 Treatment completion

Reasons for clients no longer receiving treatment from an AOD treatment service include expected cessations (for example, treatment was completed), unexpected cessations (for example, non-compliance), and administrative cessation (for example, client transferred to another service provider) (see the Glossary and Box 2.1).

In 2015–16, around 3 in 5 (61%) treatment episodes for the client's own drug use were expected or completed cessations, unexpected episode cessations accounted for about one-fifth (18%), 15% were due to other reasons, and 6% were administrative cessations. This pattern was broadly similar for completions for clients who received support for someone else's drug use, with the exception of unexpected episode completions, which were lower at 13% (compared to 18% for own drug use) (Table 5.2).

In 2015–16, treatment episodes with an expected cessation were highest where ecstasy was the principal drug of concern (87%), followed by cannabis (71%), and nicotine (70%). The lowest proportion of expected cessations was for episodes with morphine as the principal drug of concern (39%). As a group, analgesics had the lowest proportion of closed episodes with an expected cessation (54%) (Table 5.3).

Table 5.2: Closed treatment episodes, by reason for cessation and client type, 2015–16 (%)

Reason for cessation	Own drug use	Other's drug use
Expected cessation	61.3	70.0
Unexpected cessation	18.3	12.7
Administrative cessation	5.8	3.2
Other	14.6	14.1
Total	100.0	100.0

Source: Table SE.18.

About one-quarter (24%) of treatment episodes where amphetamines were the principal drug of concern had an unexpected cessation, followed by morphine (22%) and codeine (19%), while ecstasy had the lowest proportion (4.1%) (Table 5.3).

Table 5.3: Closed treatment episodes, by principal drug of concern and reason for cessation, 2015–16 (%)

Principal drug of concern	Expected cessation	Unexpected cessation	Administrative cessation	Other	Total
Analgesics					
Codeine	57.0	19.4	11.0	12.7	100
Morphine	39.4	21.8	18.2	20.6	100
Buprenorphine	51.6	18.0	15.7	14.7	100
Heroin	55.2	18.3	7.5	19.0	100
Methadone	57.3	11.3	11.2	20.3	100
<i>Total analgesics</i>	<i>53.8</i>	<i>17.9</i>	<i>10.2</i>	<i>18.0</i>	<i>100</i>
Sedatives and hypnotics					
Alcohol	65.1	18.6	19.4	11.7	100
Benzodiazepines	57.1	16.4	10.8	15.8	100
<i>Total sedatives and hypnotics</i>	<i>64.9</i>	<i>18.5</i>	<i>6.7</i>	<i>9.9</i>	<i>100</i>
Stimulants and hallucinogens					
Amphetamines	62.2	24.3	5.8	7.7	100
Ecstasy	87.2	7.1	1.6	4.1	100
Cocaine	67.5	17.5	4.8	10.2	100
Nicotine	70.2	14.7	6.9	8.3	100
<i>Total stimulants and hallucinogens</i>	<i>63.6</i>	<i>23.0</i>	<i>5.8</i>	<i>7.7</i>	<i>100</i>
Cannabis	71.2	17.1	4.0	7.7	100
Volatile solvents	63.9	19.3	3.0	14.6	100

Source: Table SE.12.

Over the 5 years to 2015–16, treatment episodes that ended in an expected cessation have decreased overall (by 4 percentage points) (Table SD.16). The decrease in expected cessation was greatest for episodes where heroin was the principal drug of concern (3 percentage points), with other drugs that have previously decreased significantly

across years, remaining consistent (alcohol decreased by only 1 percentage point and amphetamines had no change). Over the same period, unexpected cessation increased for episodes where alcohol and amphetamines were the principal drug of concern (2 percentage points and 1 percentage point respectively), and decreased by 3 percentage points for both heroin and cannabis episodes (Table SD.16).

5.6 Treatment types

Counselling was the most common treatment type provided to all clients in 2015–16 (39%), followed by assessment only (16%), and withdrawal management (8%). This pattern was consistent for clients receiving treatment for their own drug use, while for clients receiving support for someone else's drug use the most common treatment type was counselling (76%), followed by information and education only (9%), and support and case management only (8%) (Table SC.14).

In 2015–16, clients seeking treatment for their own drug use were more likely to be aged 20–49 for all treatment types (ranging from 74% to 85%), with the exception of information and education only, where clients were more likely to be aged 10–39 (83%) (Figure 5.9).

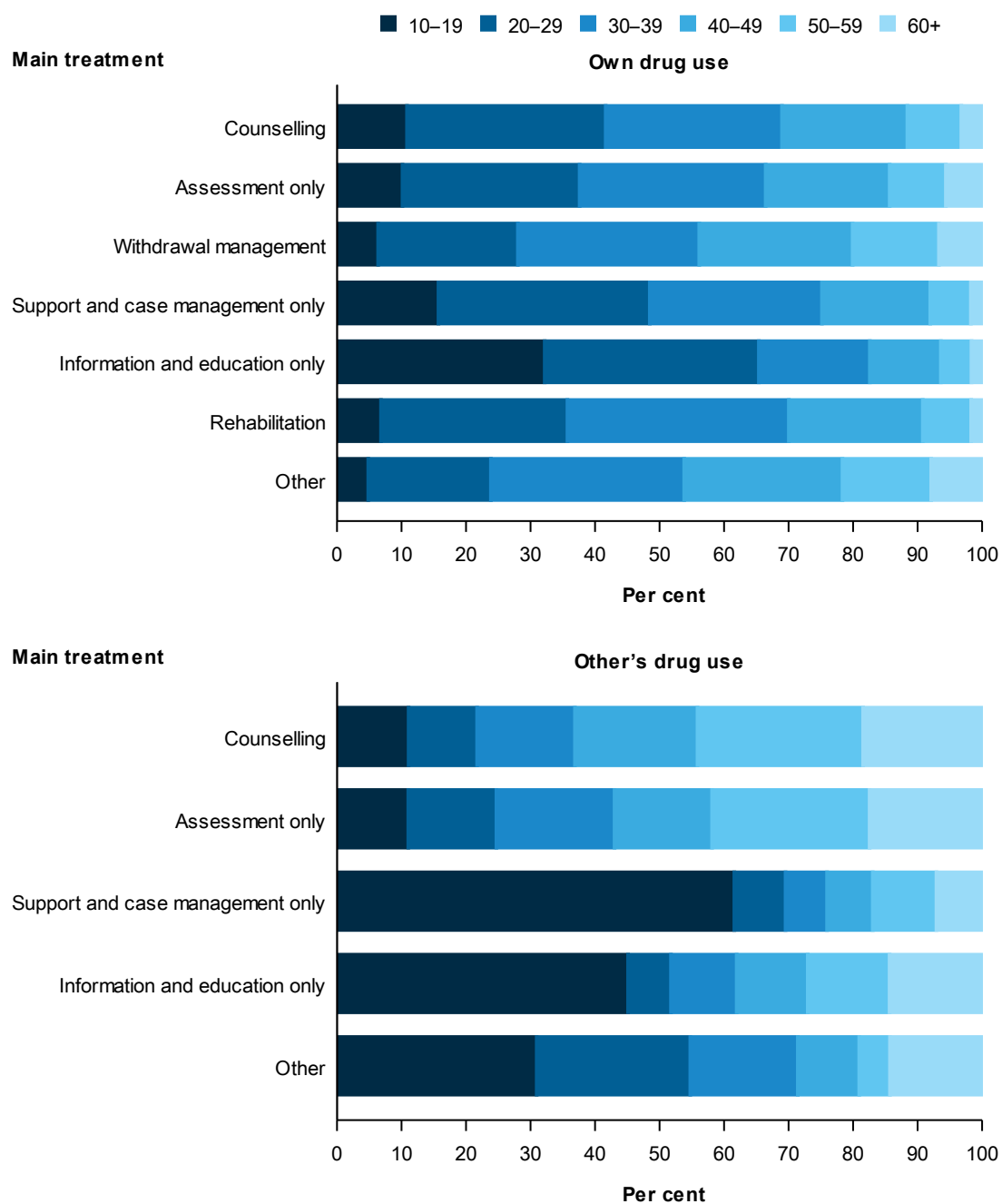
The age of clients was more varied for those seeking support for someone else's drug use. Clients receiving counselling were most likely to be aged 40 or older (63%), while those receiving information and education only, and support and case management only were most likely to be aged 10–19 (45% and 62%, respectively) (Figure 5.7; Table SC.15).

In 2015–16, the most common source of referral for clients was self/family (31%). This was consistent for all treatment types, with the exception of information and education only, where diversion was the most common source of referral (42%) (Table SC.17).

Nearly two-thirds (61%) of clients had an expected cessation (for example, their treatment was completed). This varied by treatment type—from 74% of clients receiving assessment only to 26% of those clients receiving information and education only (Table SC.19).

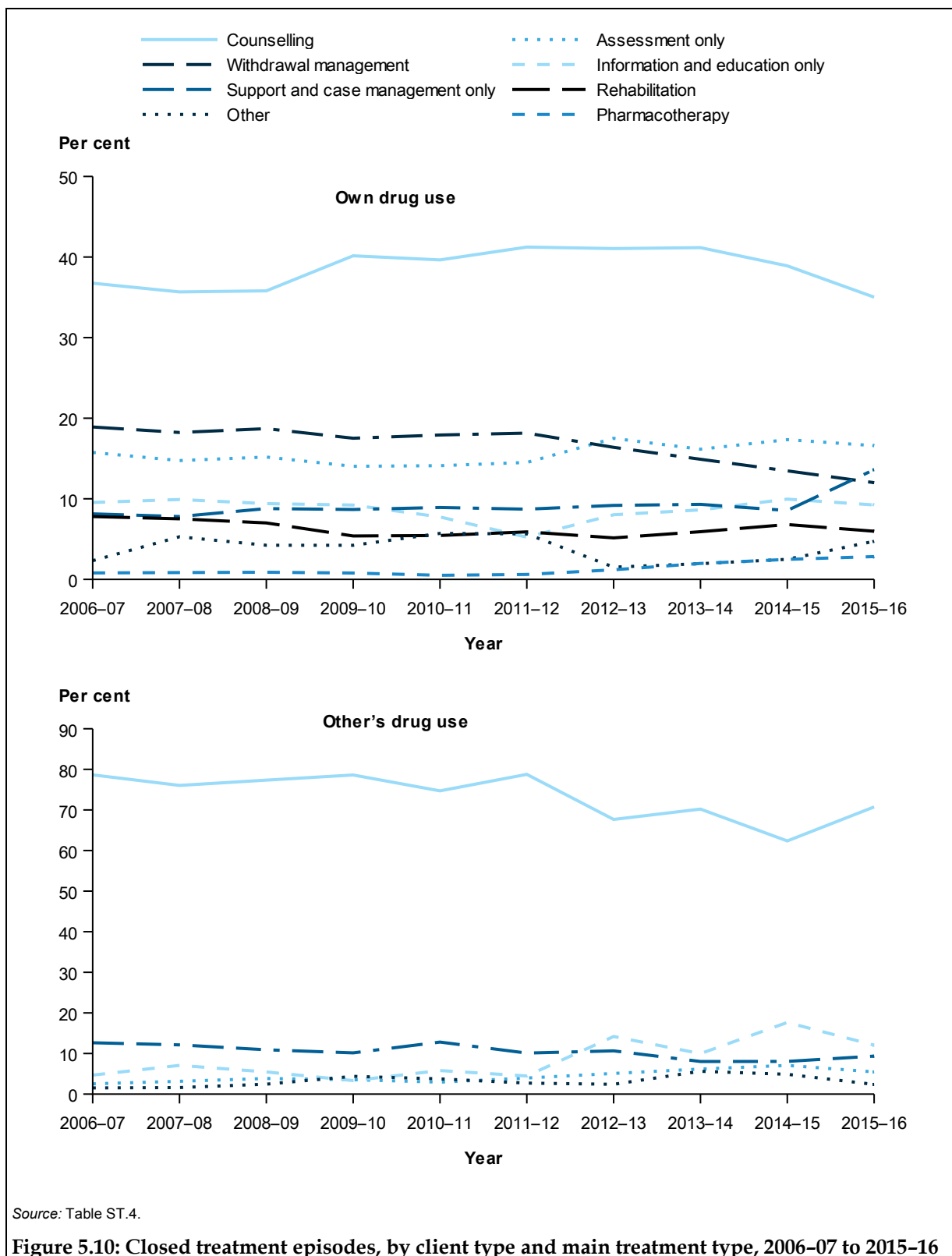
Overall since 2006–07, the proportion of episodes for each main treatment type for clients seeking treatment for their own drug use has remained fairly stable, with counselling, withdrawal management, and assessment only being the most common types of treatment.

Counselling continues to be the most common main treatment type provided (comprising about 2 in 5 episodes since 2006–07). In 2012–13, assessment only replaced withdrawal as the second most common main treatment type. This pattern of main treatment type was consistent for clients seeking treatment for their own drug use, but for those seeking support for someone else's drug use, counselling, information and education only, and support and case management only have remained the most common main treatment types over the same period (Figure 5.10; Table ST.7.2).



Source: Table SC.15.

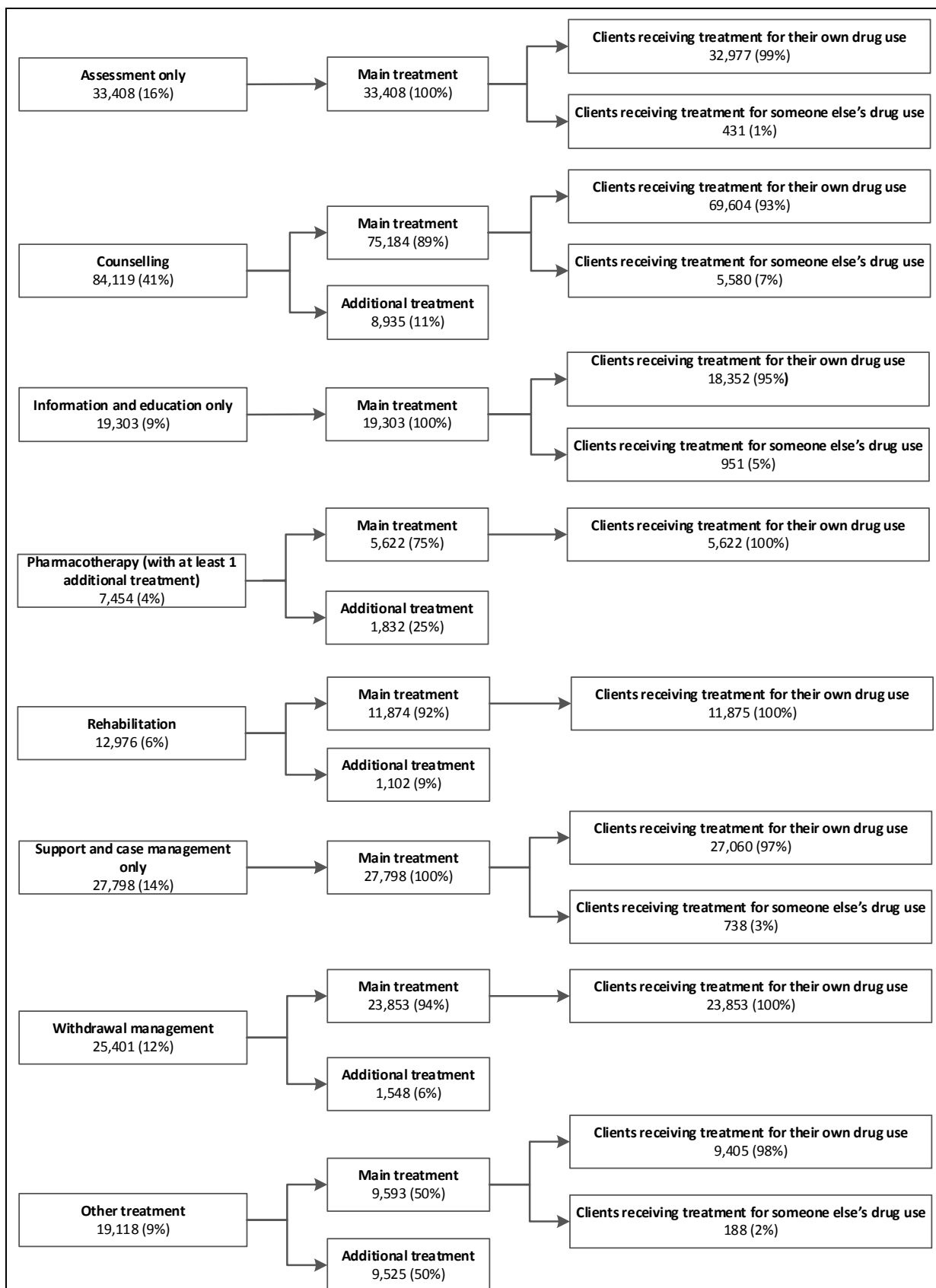
Figure 5.9: Main treatment, by client type and age group (years), 2015-16



Since 2006–07, for clients seeking treatment for their own drug use, there has been an overall increase in the proportion of episodes with counselling as the main treatment type until 2014–15 (from 37% to 39%), with it decreasing to 35% in 2015–16. Episodes with withdrawal management as the main treatment type also saw a decrease (from 19% to 12%). For clients seeking support for someone else's drug use there has been a significant decrease over the same time period in the proportion of episodes with counselling as the main treatment type (from 79% to 71%), and an increase in those episodes with information and education only as the main treatment type (from 4.7% to 12%) (Table ST.4).

Across remoteness areas, counselling was the most common treatment type in all regions. Withdrawal management (detoxification) was more common in *Major cities* (13%) than in other areas, with the lowest number of treatment episodes for withdrawal management being in *Remote* areas (4%), and for rehabilitation in *Inner regional* areas (6%) (Table SA.9).

Of the main and additional treatment types that were available to both clients receiving treatment for their own drug use and those receiving support for someone else's drug use, most episodes were for those receiving treatment for their own drug use – ranging from 93% for counselling to 100% for withdrawal management (Figure 5.11).



Sources: Tables ST.2 and ST.6.

Figure 5.11: Summary treatment characteristics (main and additional) of closed episodes, 2015–16

Counselling

Counselling is the most common treatment type for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013).

In 2015–16, over one-third (35%) of treatment episodes provided to clients for their own drug use, and over 7 in 10 (71%) episodes provided to clients for someone else's drug use, had a main treatment type of counselling (Table ST.4).

Younger males were more likely to receive counselling for their own drug use (66% of closed treatment episodes), with 39% of these episodes being provided to those aged 20–39. Clients receiving counselling for someone else's drug use were more likely to be female (65% of episodes) and aged over 40 (42%) (Table ST.19).

For clients seeking treatment for their own drug use, around 1 in 6 (16%) closed treatment episodes with a main treatment type of counselling were for Indigenous clients. For episodes where clients received support due to someone else's drug use, 12% of clients identified as Indigenous (Table ST.21).

For both client types, 1 in 7 episodes with a main treatment type of counselling lasted 1 day (14% for own drug use, and 17% for someone else's use), while over half (55% and 50%, respectively) lasted over 30 days up to six months (Table ST.26).

Over the 5 years to 2015–16, for clients receiving counselling for their own drug use, the proportion of episodes ending within 1 month remained consistent (32%), while the proportion of episodes lasting more than 1 month fell from 69% to 68% (Table ST.27). Over the same period, for clients receiving counselling for someone else's drug use, the proportion of closed episodes lasting 1 day rose from 13% to 17%, while the proportion lasting 6 months or more fell from 10% to 8% (Table ST.27).

Assessment only

Although all service providers would normally include an assessment component in all treatment types, assessment only episodes are those for which only an assessment is provided to the client. In 2015–16, 17% of treatment episodes provided to clients for their own drug use, and 6% of episodes provided to clients for someone else's drug use had a main treatment type of assessment only (Table ST.4).

Younger males aged 10–39 were more likely to receive assessment only for their own drug use – 66% of closed treatment episodes, with over half (57%) of these episodes provided to those aged 20–39. Clients receiving assessment only for someone else's drug use were more likely to be female (64%), with 45% those aged under 40 (Table ST.41).

Over the 5 years to 2015–16, for clients seeking treatment for their own drug use, the proportion of treatment episodes for clients aged 10–19 increased slightly from 8% to 9%, while the proportion for those aged 20–29 fell from 30% to 28%.

For clients seeking support for someone else's drug use, there was a decrease in the proportion of episodes provided to older clients. The majority (89%) of episodes were provided to clients aged 40 and over in 2011–12, compared with only 33% in 2015–16 (Table ST.42).

Where the main treatment type was assessment only, 14% of closed treatment episodes for clients' own drug use were for Indigenous clients, and 8% of episodes for someone else's drug use (Table ST.43).

The majority of treatment episodes lasted just 1 day – 52% of episodes for clients seeking treatment for their own drug use, and 75% of episodes for those seeking support for someone else's drug use (Table ST.45).

Over the 5 years to 2015–16, for clients seeking treatment for their own drug use, the proportion of closed episodes ending within 1 day decreased from 61% to 52%, while the proportion of episodes lasting 2–29 days increased from 23% to 26%.

For those clients seeking support for someone else's drug use, the proportion of closed episodes ending within 1 day remained consistently around 75% and episodes lasting 3–6 months decreased from 4% to 3%. The proportion of episodes for over 6 months and 1 day has decreased over the same time period, while treatment episodes lasting between 2 days and 6 months increased (Table ST.46). It is important to note that these trends are influenced by differences in jurisdictional service delivery practices and data quality improvement over time.

Withdrawal management

Withdrawal management (detoxification) includes medicated and non-medicated treatment to help manage, reduce, or stop the use of a drug of concern. This type of treatment is not available for clients seeking support for someone else's drug use.

In 2015–16, 12% of closed treatment episodes provided to clients for their own drug use had a main treatment type of withdrawal management (Table ST.4). Almost two-thirds (63%) of these episodes were provided to male clients, and 1 in 10 (10%) were for Indigenous clients (tables ST.30 and ST.32).

Over half (52%) of the treatment episodes provided for withdrawal management were for those aged 30–39 (29%) or 40–49 (24%) (Table ST.31). The majority of withdrawal management treatment episodes (83%) lasted less than 1 month (Table ST.38).

Over the 5 years from 2011–12, the proportion of closed withdrawal management episodes ending within 1 month rose from 76% to 83%, while the proportion of episodes lasting longer than 1 month fell from 24% to 17% (Table ST.38).

Support and case management only

Support includes activities such as providing emotional support to a client who occasionally calls an agency worker. Case management is usually more structured than support. It can assume a more holistic approach, taking into account all client needs – including general welfare needs – and it including assessment, planning, linking, monitoring, and advocacy (Vanderplaschen et al. 2007).

In 2015–16, 14% of episodes provided to clients for their own drug use, and 9% of episodes provided to clients for someone else's drug use had a main treatment type of support and case management only (Table ST.4).

Almost three-quarters (71%) of the closed treatment episodes provided to clients for their own drug use were for male clients, half (51%) were for clients aged 10–29, and

8% of episodes were for Indigenous clients. Female clients were more likely to be Indigenous than male clients (12% compared with 7%) (tables ST.49–51).

For clients seeking support for someone else's drug use, 61% of treatment episodes were for female clients, over half (53%) were for clients aged 10–19, and 1 in 8 (12%) were for Indigenous clients. Female clients were more likely to be Indigenous than male clients (8% compared with 5%) (tables ST.49–51).

Over the 5 years to 2015–16, there has been an increase in the proportion of episodes provided to older clients. For both client groups, those aged 40 and over increased (from 20% to 23% of episodes for clients receiving treatment for their own drug use, and from 25% to 21% for clients seeking support for someone else's drug use (Table ST.50).

Half (51%) of the support and case management only treatment episodes provided to clients for their own drug use were provided to those aged 10–19 (17%) or 20–29 (34%).

For both client types, the proportion of episodes lasting over 12 months were similar (3% for own drug use, and 4% for someone else's use), while the proportion of episodes lasting 1 day was higher for clients receiving treatment for their own drug use (43% compared with 8% for someone else's use) (tables ST.50 and ST.54).

Over the 5 years to 2015–16, episodes lasting 1 day for clients seeking treatment for their own drug use rose substantially – from 6% in 2014–15 to 43% in 2015–16. Conversely, for clients seeking support for someone else's drug use, the proportion of closed episodes remained relatively stable (Table ST.54).

Information and education only

In 2015–16, around 1 in 11 episodes provided to clients had a main treatment type of information and education only (9% of episodes for clients' own drug use, and 12% of episodes for someone else's) (Table ST.4).

Clients receiving information and education only for their own drug use were most likely to be male (69%), and younger (31% of episodes were for clients aged 10–19, and 32% for clients aged 20–29). For someone else's drug use, clients were more likely to be female (67%), and younger (41% of episodes were for clients aged 10–19).

Over the 5 years to 2015–16, the age of all clients seeking treatment for their own use remained relatively stable, but for clients seeking support for someone else's drug use, the proportion of clients aged 10–19 rose significantly, from 17% to 57% in 2014–15, then fell again to 41% in 2015–16 (tables ST.57–58).

Similar rates of closed treatment episodes were provided to clients who identified as Indigenous – 13% of closed treatment episodes for clients seeking treatment for their own drug use, and 18% of clients seeking support for someone else's drug use (Table ST.59).

As expected for this type of treatment, the majority of episodes for clients lasted just 1 day – 79% of episodes for clients seeking treatment for their own drug use, and 38% of episodes for those seeking support for someone else's drug use (Table ST.62).

Over the 5 years to 2015–16, for clients seeking treatment for their own drug use, the proportion of closed episodes ending within 1 day increased from 65% to 79%, while the proportion of episodes lasting 2–29 days fell from 17% to 10%.

For those clients seeking support for someone else's drug use, the proportion of closed episodes ending within 1 day decreased from 65% to 38%, and episodes lasting 3–6 months

decreased from 6% to 3% (Table ST.62). It is important to note that these trends were influenced by differences in jurisdictional program practices over time.

Rehabilitation

Rehabilitation focuses on helping clients to cease their drug use, and to prevent psychological, legal, financial, social, and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities, and community-based rehabilitation services (AIHW 2011). Note that this type of treatment is not available for clients seeking support for someone else's drug use.

In 2015–16, 6% of closed treatment episodes provided to clients for their own drug use had a main treatment type of rehabilitation. Two-thirds (66%) of these episodes were provided to male clients, and about one-fifth (21%) were for Indigenous clients (tables ST.4, ST.65 and ST.67).

Almost two-thirds (64%) of the treatment episodes provided for rehabilitation were for clients aged 20–29 (30%), or 30–39 (34%). More than one-third (35%) of the episodes lasted 1–3 months, while a further 31% lasted 2–29 days (tables ST.66 and ST.73).

Over the 5 years to 2015–16, the duration of closed episodes for those clients seeking treatment for their own drug use remained relatively stable (Table ST.73).

Pharmacotherapy

Pharmacotherapy is the replacement of a person's drug of choice with a legally prescribed and dispensed substitute. Pharmacotherapy programs are available for a range of drugs, including alcohol and opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category.

Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy. Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment with an additional treatment provided are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded.

Pharmacotherapy is only available to clients receiving treatment for their own drug use. Because most pharmacotherapy services are outside the scope of the AODTS NMDS, the data presented on pharmacotherapy episodes are a significant under-representation. More information on opioid pharmacotherapy treatment provided in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics at www.aihw.gov.au/alcohol-and-other-drugs/data-sources/nopsad-2016/.

For services that were in scope of the AODTS NMDS in 2015–16, 3% of treatment episodes were provided with a treatment type of pharmacotherapy (main or additional). In one-quarter (25%) of these episodes, pharmacotherapy was an additional treatment (tables ST.4 and ST.75).

About two-thirds (65%) of pharmacotherapy treatment episodes were provided to male clients, and 13% were for Indigenous clients. Over two-thirds (68%) of episodes were for those aged 30–39 (41%), or 40–49 (27%). A further 19% were for clients aged 20–29, while just 2% were for clients aged 60 and over (tables ST.76–78).

Of the closed episodes where pharmacotherapy was the main treatment type, more than one-third (37%) lasted over 12 months, while a further one-quarter (25%) lasted 3–12 months (Table ST.84).

More than two-fifths (44%) of pharmacotherapy episodes had heroin as a principal drug of concern, while almost 1 in 9 (9%) had a principal drug of methadone.

Pharmacotherapy is commonly reported as an additional treatment in the AODTS NMDS. The most common principal drugs of concern with additional treatment episodes of pharmacotherapy include alcohol (37%), followed by amphetamines (19%), cannabis (15%), and heroin (10%) (Table ST.80).

Appendix A: Data and methods

Age

Age is calculated as at the start of the episode.

Data collection process

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning and policy. Figure A1 shows the processes involved in constructing the national data.

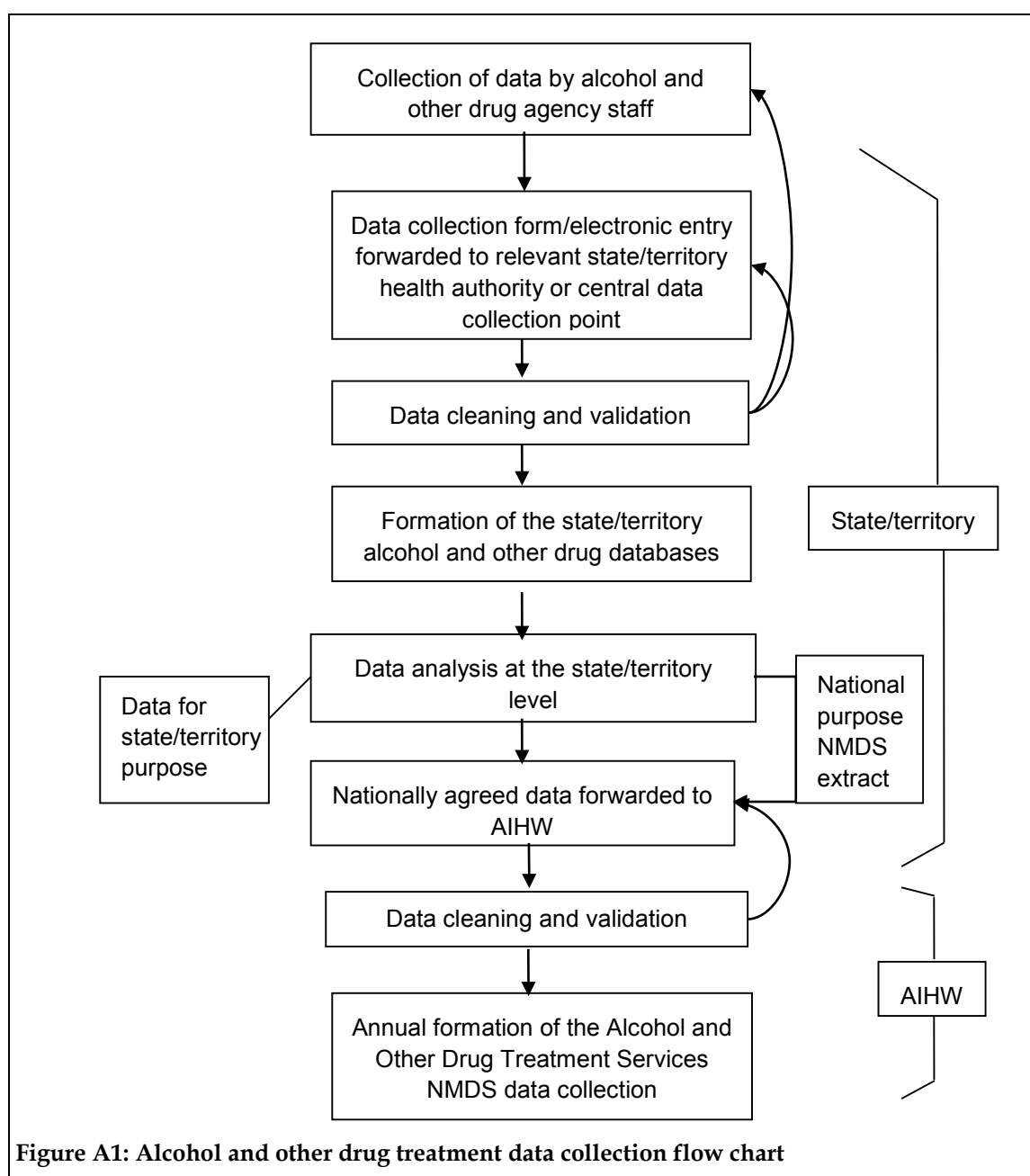


Figure A1: Alcohol and other drug treatment data collection flow chart

Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's Australian Standard Classification of Drugs of Concern (ASCDC) (ABS 2011a). In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	ASCDC codes	Category	Includes
Analgesics	1000–1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other opioids	Oxycodone, fentanyl, pethidine
		Other analgesics	Paracetamol
Sedatives and hypnotics	2000–2999	Alcohol	Ethanol, methanol and other alcohols
		Benzodiazepines	Clonazepam, diazepam and temazepam
		Other sedatives and hypnotics	Ketamine, nitrous oxide, barbiturates and kava
Stimulants and hallucinogens	3000–3999	Amphetamines	Amphetamine, dexamphetamine and methamphetamine
		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	Volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Cannabinoids	7000–7199	Cannabis	
Other	4000–6999	Other	Anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
	9000–9999		
Not stated	0000–0002	Not stated	

In this report, pharmaceutical drugs were grouped using 10 drug types, making up the pharmaceuticals group for the purposes of the analysis. These drugs correspond to the ASCDC codes and classifications (Table A2).

Table A2: Pharmaceutical drugs of concern, ASCDC codes and classifications

Drug category	ASCDC code	ASCDC classification (broad group and narrow group/s)	Drug description (ASCDC base level unit/s)
Codeine	1101	Analgesics Organic opiate analgesics	Codeine
Morphine	1102	Analgesics Organic opiate analgesics	Morphine
Buprenorphine	1201	Analgesics Semisynthetic opioid analgesics	Buprenorphine
Oxycodone	1203	Analgesics Semisynthetic opioid analgesics	Oxycodone
Methadone	1305	Analgesics Synthetic opioid analgesics	Methadone
Benzodiazepines	2400–2499	Sedatives and hypnotics Benzodiazepines	Benzodiazepines n.f.d., alprazolam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam, benzodiazepines n.e.c.
Steroids	4000–4999	Anabolic agents and selected hormones Anabolic androgenic steroids Beta2 agonists Peptide hormones, mimetics and analogues Other anabolic agents and selected hormones Not further defined	Anabolic agents and selected steroids n.f.d., anabolic androgenic steroids n.f.d., boldene, dehydroepiandrosterone, fluoxymesterone, mesterolone, methandriol, methenolone, nandrolone, oxandrolone, stanozolol, testosterone, anabolic androgenic steroids n.e.c., beta2 agonists n.f.d., eformoterol, fenoterol, salbutamol, beta2 agonists n.e.c., peptide hormones, mimetics and analogues n.f.d., chorionic gonadotrophin, corticotrophin, erythropoietin, growth hormone, insulin, peptide hormones, mimetics and analogues n.e.c., other anabolic agents and selected hormones n.f.d., sulfonylurea hypoglycaemic agents, tamoxifen, thyroxine, other anabolic agents and selected hormones n.e.c.
Other opioids	1100, 1199, 1200, 1298–1299, 1300–1304, 1306–1399	Analgesics Organic opiate analgesics Semisynthetic opioid analgesics Synthetic opioid analgesics Not further defined	Organic opiate analgesics n.f.d., organic opiate analgesics n.e.c., semisynthetic opioid analgesics n.f.d., semisynthetic opioid analgesics n.e.c., synthetic opioid analgesics n.f.d., fentanyl, fentanyl analogues, levomethadyl acetate hydrochloride, meperidine analogues, pethidine, tramadol, synthetic opioid analgesics n.e.c.
Other analgesics	0005, 1000, 1400–1499	Analgesics Non-opioid analgesics Not further defined	Analgesics n.f.d., non-opioid analgesics n.f.d., acetylsalicylic acid, paracetamol, ibuprofen, non-opioid analgesics n.e.c.
Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999	Sedatives and hypnotics Anaesthetics Barbiturates Gamma-hydroxybutyrate (GHB) type drugs and analogues Other sedatives and hypnotics	Sedatives and hypnotics n.f.d., anaesthetics n.f.d., ketamine, nitrous oxide, phencyclidine, propofol, anaesthetics n.e.c., barbiturates n.f.d., amylobarbitone, methylphenobarbitone, phenobarbitone, barbiturates n.e.c., GHB-type drugs and analogues n.f.d., GHB, gamma-butyrolactone, 1,4-butanediol, GHB-type drugs and analogues n.e.c., other sedatives and hypnotics n.f.d., chlormethiazole, kava lactones, zopclon, doxylamine, promethazine, zolpidem, other sedatives and hypnotics n.e.c.

n.f.d.—not further defined; n.e.c.—not elsewhere classified.

Duration

Duration is calculated in whole days, and only for closed episodes.

Population rates

In this publication, crude rates were calculated using the ABS's estimated resident population at the midpoint of the data range—that is, rates for 2015–16 data were calculated using the estimated resident population at 31 December 2015.

Reason for cessation

The AODTS NMDS contains data on the reason an episode ended (reason for cessation). In this report, these reasons are grouped (Table A3), but data for the individual end reasons are available in the online supplementary tables.

A different method was used for grouping end reasons in reports released before 2014, so trend comparisons across reports should be made with caution. It is possible to compare data at the individual end reasons using the supplementary tables.

Table A3: Grouping of cessation reasons, by indicative outcome type

Outcome type	Reason for cessation
Expected cessation	Treatment completed
	Ceased to participate at expiration
	Ceased to participate by mutual agreement
Unexpected cessation	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Administrative cessation	Change in main treatment type
	Change in delivery setting
	Change in principal drug of concern
	Transferred to another service provider
Other	Drug court or sanctioned by court diversion service
	Imprisoned (other than drug court sanctioned)
	Died
	Other
	Not stated

Remoteness area

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure 2011 (ABS 2011b) to analyse the remoteness of AOD treatment agencies. This structure allows areas that share common characteristics of remoteness to be classified into broad geographic regions of Australia. These areas are:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Remote*
- *Very remote.*

The remoteness structure divides each state and territory into several regions based on their relative access to services.

Examples of urban centres in each remoteness area are:

- *Major cities* Canberra, Newcastle
- *Inner regional* Hobart, Bendigo
- *Outer regional* Cairns, Darwin
- *Remote* Katherine, Mount Isa
- *Very remote* Tennant Creek, Meekatharra.

For this report, the remoteness of the agency was determined using the Statistical Area level 2 (SA2) of the agency. Some statistical areas are split between multiple remoteness areas. Where this was the case, the data were weighted according to the proportion of the population of the statistical areas in each remoteness area.

The Australian Statistical Geography Standard ASGS has replaced the Australian Standard Geographical Classification 2006 (ABS 2006), which was used in previous reports to calculate remoteness areas. Therefore, remoteness data for 2011–12 and previous years are not comparable with that for 2012–13 and subsequent years.

Service sectors

From 2008–09, agencies funded by the Australian Government Department of Health under the Non-Government Organisation Treatment Grants Program (NGOTGP) were classified as non-government agencies. Before this, many of these agencies were classified as government agencies. As a result, trends in service sectors of agencies should be interpreted with caution.

Trends

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia*, due to data revisions.

Appendix B: Imputation methodology for alcohol and other drug treatment services clients

From the inception of the AODTS NMDS, data have been collected only about treatment episodes provided by AOD treatment services. Data about the clients those episodes relate to have not been available at a national level. An SLK was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continuing to ensure the privacy of these individuals receiving treatment.

An imputation strategy for the collection was developed to correct for the impact of invalid or missing SLKs on the total number of clients. This strategy takes into account several factors relating to the number of episodes per client, and makes assumptions relating to spread across agencies. It also takes into consideration the likelihood that an episode with a missing SLK relates to a client that has already been counted through other episodes with a valid SLK.

To ensure an accurate representation of the AODTS client population, imputation was applied to the 2012–13, 2013–14, and 2015–16 AODTS NMDS to account for the proportion of valid SLKs being less than 95% for these years. The national rate of valid SLKs for these years was largely affected by low proportions of valid SLKs in New South Wales.

Following imputation of the 2015–16 data, the estimated number of clients at a national level increased from 114,487 in 2014–15 to 133,895 in 2015–16.

Table B1: Imputed numbers of clients, by state and territory, 2015–16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of episodes	47,371	64,118	44,534	24,206	11,430	3,840	5,914	5,222	206,635
Number of episodes with valid SLKs	43,241	63,285	43,969	24,095	11,280	3,783	5,867	5,020	200,540
Percentage of episodes with valid SLKs	91.28	98.70	98.73	99.54	98.69	98.52	99.21	96.13	97.05
Number of episodes with invalid SLKs	4,130	833	565	111	150	57	47	202	6,095
Number of distinct clients (from valid SLKs)	27,308	33,061	35,419	17,847	8,026	2,936	3,505	3,126	131,228
Imputed number of clients	29,071	33,312	35,800	17,912	8,109	2,973	3,524	3,209	133,895

Attributing the number of clients to a set of missing SLK records

The AODTS NMDS collects information at the service record level. Service records are associated with individual clients through an SLK. There are a number of records that have missing or invalid SLK data that cannot be attributed to a client. This leads to an under-reporting of the total number of clients using the services, as some (but not all) of the records will belong to clients who are not observed via a valid SLK.

This document describes the method of using the available data – after making several assumptions about the behaviour of the whole population – to estimate the total number of clients.

Imputation groups

Imputation groups are formed to improve the performance of the estimates. The service records were grouped according to properties that are thought to influence the behaviour of clients and the quality of SLK data, and then the imputation was performed at this imputation group level.

Possible properties used to develop groups include location, provider size (measured by number of service records), and service type. The data are also grouped according to any subpopulations that are going to be reported upon, such as jurisdiction.

The final imputation groups were formed by balancing the often-competing priorities of having homogenous groups, and the need to have groups large enough to ensure that the imputation is robust.

Assumptions and approximations

Assumption 1: randomness and independence

This imputation method assumes that whichever service provider a client attends for each incidence of service is random and independent of any other incidents of service the client may have. It is further assumed that the validity or otherwise of the SLK recorded on each service record is random, and independent of both the client and the service provider with which the record is associated.

Assumption 2: distribution of the number of service records per client

This method also assumes that the distribution of the number of records per client for all clients is similar to that observed using the subset of records with valid SLKs.

Approximation 1: no client has more than 10 service records

This imputation method uses the approximation that no client has more than 10 service records.

In order to implement this approximation, any clients observed to have more than 10 service records were treated as if they had only 10, and the proportion of clients with 10 service records calculated accordingly.

Notation

The definition of the notation used in this document is as follows:

N_t :	the (unknown) total number of clients
N'_t :	the imputed total number of clients
N_{SLK1} :	the number of clients observed using the records with a valid SLK
P_{SLK1} :	the proportion of clients with at least 1 service record with a valid SLK
P_{Ni} :	the (unknown) proportion of clients with i service records
P'_{Ni} :	the imputed proportion of clients with i service records
$P_{Ni,SLK1}$:	the proportion of clients with i service records as observed using records with valid SLKs
n_t :	the total number of service records

- $n_t | N_t, P_{Ni}$: the number of service records given the total number of clients and the proportions of clients with i service records, $i = 1, 2, \dots, 10$
- n_{SLK1} : the number of service records with a valid SLK
- n_{SLK0} : the number of service records with an invalid SLK
- p_{SLK0} : the proportion of service records with an invalid SLK.

Methodology

Given Assumption 1 and Approximation 1, the proportion of clients who have at least 1 service record with a valid SLK is:

$$P_{SLK1} = \sum_{i=1}^{10} P_{Ni} (1 - p_{SLK0}^i)$$

Now:

$$N_{SLK1} = P_{SLK1} \times N_t$$

so it follows that the total number of clients is:

$$N_t = \frac{N_{SLK1}}{P_{SLK1}}$$

To resolve this equation for N_t the values of the P_{Ni} is required. These are unknown, given it is not possible to observe the whole population due to the records with invalid SLK values. This method imputes the unknown P_{Ni} using numerical methods, then uses these values to impute N_t .

The process starts with the distribution of number of records per client that were observed using the records with valid SLKs ($P_{Ni,SLK1}$). These values are then adjusted so that the following conditions are met.

Constraint 1

The sum of the imputed proportions is equal to 1. That is:

$$\sum_{i=1}^{10} P'_{Ni} = 1$$

Constraint 2

The imputed proportion of clients with 1 service record is less than or equal to the observed equivalent proportion among clients with records with valid SLKs. That is:

$$P'_{N1} \leq P_{N1,SLK1}$$

This constraint is used because some of the clients observed to have only 1 record will, in fact, have additional records with invalid SLKs. It is unlikely that the true proportion of clients with 1 service record is higher than that observed using records with valid SLKs.

Constraint 3

The total number of service records that the imputed total number of clients and the imputed distribution of records per client imply is equal to the observed number of service records.

That is:

$$n_t | N'_t, P'_{Ni} = N'_t \sum_{i=1}^{10} (i \times P'_{Ni}) = n_t.$$

This constraint is used to ensure that the imputed values are consistent with the observed number of records.

Penalty function

Under Assumption 2 we want to limit how much the imputed proportions differ from the proportions observed via the records with valid SLK data. To achieve this we use a penalty function that increases as the distance between the imputed and observed proportions increases. This function is defined to be:

$$f(P_{N1,SLK1}, P_{N2,SLK1}, \dots, P_{N10,SLK1}, P'_{N1}, P'_{N2}, \dots, P'_{N10}) = \sum_{i=1}^{10} \frac{(P'_{Ni} - P_{Ni,SLK1})^2}{P_{Ni,SLK1}}$$

Using numerical methods, the $P'_{N1}, P'_{N2}, \dots, P'_{N10}$ are chosen such that the penalty function is minimised, subject to the 3 constraints.

The final step is to use the imputed proportions to calculate the imputed total number of clients:

$$N'_t = \frac{N_{SLK1}}{\sum_{i=1}^{10} P'_{Ni} (1 - p_{SLK0}^i)}$$

The resulting number is then rounded to the nearest integer.

Discussion

This imputation technique uses available information to impute the total number of clients. The methodology takes into account the proportion of records with invalid SLK data, and the distribution of the number of service records per client, as observed via the records with valid SLK data. It is apparent that the assumptions made do not hold for every client or service record. It is reasonable to expect that a client's attendance at a service provider will be affected by location and any prior contact they had with a provider. It should also be noted that some service providers failed to collect SLK for any service record during the reference period.

Despite the known cases where Assumption 1 does not hold, it is reasonable to hope that, across the population as a whole, the assumption is a reasonable representation of the populations of clients and service records.

It is believed that the impact of Approximation 1 will be small because, given Assumption 1, the chance that a client with more than 10 service records is not observed via a record with a valid SLK is extremely small. The chance diminishes as the proportion of records with an invalid SLK decreases and across jurisdictions the highest proportion observed is about 0.3. It should also be noted that the largest proportion of clients with 10 or more service records observed in the data at the jurisdiction level was only 0.007.

There are many different penalty functions that could be used in this imputation. The function used was chosen because, compared to the other penalty functions investigated, it produced imputed proportions that were generally as close or closer to the observed

proportions. It also most consistently resulted in a distribution that was similar in shape to the observed distribution of the number of records per client.

Glossary

additional drugs: Clients receiving treatment for their own drug use nominate a principal drug of concern that has led them to seek treatment and additional drugs of concern, of which up to 5 are recorded in the AODTS NMDS. Clients receiving treatment for someone else's drug use do not nominate drugs of concern.

additional treatment type: Clients receive 1 main treatment type in each episode, and additional treatment types as appropriate, of which up to 4 are recorded in the AODTS NMDS.

administrative cessation: Includes episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

alcohol: A central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres, and makes judgement, coordination, and balance more difficult.

amphetamines: Stimulants that include methamphetamine, also known as methylamphetamine. Amphetamines speed up the messages going between the brain and the body. Common names are speed, fast, up, uppers, louee, goey, and whiz. Crystal methamphetamine is also known as ice, shabu, crystal meth, base, whiz, goey, or glass.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The Australian Statistical Geography Standard replaced the Australian Standard Geographical Classification in July 2011.

benzodiazepines: Also known as minor tranquillisers, are most commonly prescribed by doctors to relieve stress and anxiety, and to help people sleep. Common names include Benzos, tranx, sleepers, downers, pills, serras (Serepax®), moggies (Mogadon®), and normies (Normison®).

client type: The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person. Clients may seek treatment or assistance concerning their own alcohol and/or other drug use, or support and/or assistance in relation to the alcohol and/or other drug use of another person.

closed treatment episode: A period of contact between a client and a treatment provider, or team of providers. An episode is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months, or when treatment is ceased (see **reason for cessation**).

cocaine: A drug that belongs to a group of drugs known as stimulants. Cocaine is extracted from leaves of the coca bush (*Erythroxylum coca*). Some of the common names for cocaine include C, coke, nose candy, snow, white lady, toot, Charlie, blow, white dust, and stardust.

diversion client type: Clients who received at least 1 AOD treatment episode during a collection year resulting from a referral by a police or court diversion program. The 2 subtypes in this group are:

- diversion only clients – received treatment as a result of diversion referrals only
- diversion client with non-diversion episodes – received at least 1 treatment episode resulting from a diversion referral, but also received at least 1 treatment episode resulting from a non-diversion referral in a collection year.

ecstasy: The popular street name for a range of drugs containing the substance 3, 4-methylenedioxymethamphetamine (MDMA) – a stimulant with hallucinogenic properties. Common names for ecstasy include Adam, Eve, MDMA, X, E, the X, XTC, and the love drug.

expected cessation: Includes episodes where the treatment was completed, or where the client ceased to participate at expiation, or by mutual agreement.

government agency: An agency that operates from the public accounts of the Australian Government or a state or territory government, is part of the general government sector, and is financed mainly from taxation.

heroin: 1 of a group of drugs known as opioids, which are strong pain-killers with addictive properties. Heroin and other opioids are classified as depressant drugs. Common names for heroin include smack, skag, dope, H, junk, hammer, slow, gear, harry, big harry, horse, black tar, China white, Chinese H, white dynamite, dragon, elephant, boy, home-bake, or poison.

illicit drug use: Includes:

- the use of illegal drugs – drugs that are prohibited from manufacture, sale, or possession in Australia, such as cannabis, cocaine, heroin, and ecstasy
- misuse, non-medical or extra-medical use of pharmaceuticals – drugs that are available from a pharmacy, over-the-counter, or by prescription, which may be subject to misuse, such as opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine, and steroids
- use of other psychoactive substances – legal or illegal, potentially used in a harmful way, such as kava, or inhalants such as petrol, paint, or glue (but not including tobacco or alcohol).

licit drug use: The use of legal drugs in a legal manner, including tobacco smoking and alcohol consumption.

main treatment type: The principal activity that is determined at assessment by the treatment provider to treat the client's alcohol or other drug problem for the principal drug of concern.

median: The midpoint of a list of observations ranked from the smallest to the largest.

nicotine: The highly addictive stimulant drug in tobacco.

non-government agency: An agency that receives some government funding, but is not controlled by the government, and is directed by a group of officers or an executive committee. A non-government agency might be an income tax-exempt charity.

principal drug of concern: The main substance that the client stated led them to seek treatment from an alcohol and drug treatment agency.

reason for cessation: The reason the client ceased to receive a treatment episode from an alcohol and other drug treatment service. The client can have:

- **ceased to participate against advice:** Where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- **ceased to participate at expiation:** Where the client has fulfilled their obligation to satisfy expiation requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme, and chooses not to continue with further treatment
- **ceased to participate by mutual agreement:** Where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area
- **ceased to participate involuntarily:** Where the service provider stops the treatment due to non-compliance with the rules or conditions of the program
- **ceased to participate without notice**
- **change in the delivery setting**
- **change in the principal drug of concern**
- **change in the main treatment type**
- **death**
- **distinct clients:** Where the total number refers to actual number of clients counted
- **drug court or sanctioned by court diversion service:** Where the client is returned to court or jail due to non-compliance with the program
- **estimated clients:** Where the number of clients is estimated using imputed numbers (see imputation methodology)
- **imprisoned (other than sanctioned by a drug court or diversion service)**
- **treatment completed:** Where the treatment was completed as planned
- **transferred to another service provider:** Including where the service provider is no longer the most appropriate, and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services, or between residential services and a hospital – excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment.

referral source: The source from which the client was transferred or referred to the alcohol and other drug treatment service.

standard drink: Contains 10 grams of alcohol (equivalent to 12.5 millilitres of alcohol). Also referred to as a full serve.

tobacco: See **nicotine**.

treatment episode: The period of contact between a client and a treatment provider or a team of providers. Each treatment episode has 1 principal drug of concern and 1 main treatment type. If the principal drug or main treatment changes, then a new episode is recorded.

treatment type: The type of activity that is used to treat the client's alcohol or other drug problem, which includes:

- **assessment only:** Where only assessment is provided to the client (service providers would normally include an assessment component in all treatment types)
- **counselling:** Can include cognitive behaviour therapy, brief intervention, relapse intervention, and motivational interviewing
- **information and education only**
- **pharmacotherapy:** Where the client receives another type of treatment in the same treatment episode, and includes drugs such as naltrexone, buprenorphine, and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids; where a pharmacotherapy is used for withdrawal, it is included in the **withdrawal** category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy
- **rehabilitation:** Focuses on helping clients to stop their drug use, and to prevent psychological, legal, financial, social, and physical consequences of problematic drug use; rehabilitation can be delivered in several ways, including residential treatment services, therapeutic communities, and community-based rehabilitation services
- **support and case management only:** Support includes helping a client who occasionally calls an agency worker for emotional support, while case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs – including general welfare needs – and it includes assessment, planning, linking, monitoring, and advocacy
- **withdrawal management (detoxification):** Includes medicated and non-medicated treatment to help manage, reduce, or stop the use of a drug of concern.

unexpected cessation: Includes episodes where the client ceased to participate against advice, without notice, or due to non-compliance.

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Related publications

This report, *Alcohol and other drug treatment services in Australia 2015–16*, is part of an annual series. This publication, as well as past reports in this series, can be downloaded free from the AIHW website, <www.aihw.gov.au/alcohol-and-other-drugs-publications/>.

The website also includes information on ordering printed copies.

The following AIHW publications relating to alcohol and other drug use might also be of interest:

- AIHW (Australian Institute of Health and Welfare) 2014. Alcohol and other drug treatment and diversion from the Australian criminal justice system 2012–13. Bulletin no. 125. Cat. no. AUS 186. Canberra: AIHW.
- AIHW 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.
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- AIHW 2015. Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results 2013–14. Aboriginal and Torres Strait Islander health services report no. 6. Cat. no. IHW 152. Canberra: AIHW.
- AIHW 2015. National opioid pharmacotherapy statistics 2014. Bulletin no. 128. Cat. no. AUS 190. Canberra: AIHW.

In 2015–16, about 796 alcohol and other drug treatment services provided just over 206,600 treatment episodes to an estimated 134,000 clients.

The top 4 drugs that led clients to seek treatment were alcohol (32% of treatment episodes), cannabis (23%), amphetamines (23%), and heroin (6%). The proportion of episodes where clients were receiving treatment for amphetamines has continued to rise over the 5 years to 2015–16, from 12% of treatment episodes in 2011–12 to 23% in 2015–16. The median age of clients in AOD treatment services is rising, from 31 in 2006–07 to 33 in 2015–16.